MENTAL DISORDERS ENCOUNTERED IN COUNSELLING

A TEXTBOOK OF CLINICAL PHSYCHOLOGY BASED ON DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS - IV

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Mary, Mother of the Good Shepherd Province

Represented by the Provincial

Fr. Louis Mousseau,O.F.M.Cap.,

Who Educated Me in Pastoral Counselling

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INTRODUCTION

As I was going on a regular basis to Centre for Addiction and Mental Health at Queen Street West, Toronto, for my counselling practice, I was called upon to attend to a patient in another branch of the institution. As directed, I went to the 9th floor and enquired the duty nurse about the patient I was supposed to meet. I was led into a lounge where I waited for the arrival of the patient. A young girl of 21 years was brought to me. She looked drowsy and was slurred in her speech. She was admitted there two weeks back.

The reason for her admission was that she was having irresistible suicidal ideation and wanted to kill herself with an overdose of drugs. In her conversation she told me that she was afraid of God since God would be mad at her for the suicidal thoughts she cherished, because life belongs to God and to have planned to take it away would offend God; Now her fear was that God would punish her.

In ordinary circumstances I would have proceeded to do non-directive counselling. But in this case I had to be directive because of the type of client, the type of problem, and the degree of severity of the problem. In counselling we not only meet ordinary people, but also people who are struggling with mental health issues (mental disorders) and for that reason the counsellor needs to have a workable knowledge of the various types of mental disorders and their levels of severity in order to be effective in counselling. The knowledge that the girl was suffering from mental disorders and the high level of severity sufficiently indicated that I needed to be directive in my counselling. She needed a lot of reassurance that God would not punish her since God is a loving father.

After having written some books on Counselling, I thought of writing a book on mental disorders so that the counsellor trainees or the care-givers are well prepared to meet all types of care seekers. Therefore my attempt in writing this book is to give a fair and synthesized knowledge of the classification of mental disorders and how to do counselling for them. Hence the book goes under the title 'Mental Disorders Encountered in Counselling.'

Over the last 25 years, advances in research on the brain have progressed at a rapidly increasing pace and have reached the point that neuroscience can justifiably be considered the biomedical foundation of psychiatry. Logarithmic growth in our understanding of the organization and function of the brain has made it feasible to begin to analyse behaviour at the systems, cellular, and molecular levels. Methodologies such as nuclear magnetic resonance imaging and spectroscopy and position-emission tomography now permit us to characterize structural, metabolic, and physiological abnormalities in the brains of live psychiatric patients. Parallel advances at the cellular and molecular levels will permit us to define genetic vulnerability for disorders of behaviour and, ultimately, to determine the molecular and cellular mechanisms responsible for psychiatric disorders. These developments are progressively narrowing the Cartesian separation between the mind and brain by improving our ability to correlate mental experience with brain processes.

Psychiatry, as the medical speciality primarily involved in the diagnosis and management of behavioural disorders, must by necessity incorporate neuroscience into its scientific foundation. Based on the breathtaking growth in neuroscience research over the last decade, advances in the understanding of the structure, organization, and function of the brain promise to offer powerful new methods of diagnosing psychiatric disorders, clarifying their pathophysiology, and developing more specific and effective therapies.

Uncovering the molecular mechanisms involved in psychopathology will raise a host of questions about gene-environment interactions, including protective mechanisms that modify or prevent the expression of psychiatric disorders in those individuals who are genetically vulnerable. Thus, insights into the pathophysiology of mental illness and the disparity between phenotypic characteristics and genetic endowments will ultimately lead to a better understanding of factors that determine 'mental wellness' as well as illness.[1]

1. Classification

The classification of mental disorders has undergone a tortuous history. First of all we need to define what is meant by 'mental disorders' before we are able to classify them. Now, we have a workable definition in the latest classification of mental disorders in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV).

2. Definition of Mental Disorder

The phrase 'mental disorder' immediately puts in mind a distinction between 'mental' and 'physical' disorder that smacks of a mind/body dualism. There is so much of evidence to show that there is much 'physical' in 'mental' disorders and much 'mental' in 'physical' disorders. Since no better adequate term could be found to express the reality of illness, the term 'mental' is retained in DSM-IV. The term 'mental disorder' lacks a consistent operational definition that covers all situations as many other concepts in medicine and science.

A mental disorder is a clinically significant behaviour or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

Firstly the syndrome must not be merely an expected and culturally sanctioned response one makes to a particular event like the bereavement reaction to the loss of a loved one. Secondly whatever its original cause, it must be manifested as a behavioural, psychological or biological dysfunction in a person. Thirdly it is not a deviant behaviour (e.g., political, religious, or sexual) or a conflict that is primarily between the individual and society unless the deviance or conflict is a symptom of dysfunction in the person as described in the definition. One needs to keep in mind that the classification of mental disorders is not the classification of people.

The DSM-IV classification divides mental disorders into types based on criteria sets with defining features. This works best when all members of a diagnostic class are homogeneous, when there are clear boundaries between classes, and when the different classes

are mutually exclusive. But each category of mental disorder is not a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder. And no individuals who are diagnosed as having the same mental disorders are alike in important ways. It would have been better if the classification by DSM-IV were a dimensional model rather than the categorical model. A dimensional system classifies clinical presentations based on quantification of attributes rather than the assignment to categories and works best in describing phenomena that are distributed continuously and that do not have clear boundaries. Keeping in mind this limitation involved in defining the term 'mental disorders' and classifying them, one needs to proceed cautiously in labelling individuals.[2]

3. Psychosis and Neurosis

The traditional meaning of the term 'psychotic' emphasized loss of reality testing and impairment of mental functioning – manifested by delusions, hallucinations, confusions, and impaired memory. However, two other meanings have evolved during the past 50 years. In the most common psychiatric use of the term, 'psychotic' became synonymous with severe impairment of social and personal functioning characterized by social withdrawal and inability to perform the usual household and occupational roles. The other meaning signifies the degree of ego regression as the criterion for psychotic illness. As a consequence of these multiple meanings, the term has lost its precision in current clinical and research practice. In DSM-IV 'psychotic' means grossly impaired in reality testing; i.e., persons incorrectly evaluate the accuracy of their perceptions and thoughts and make incorrect inferences about external reality, even in the face of contrary evidence. Direct evidence of psychotic behaviour is the presence of either delusions or hallucinations without insight into their pathological nature.

A neurosis is a chronic or recurrent nonpsychotic disorder, characterized mainly by anxiety, that is experienced or expressed directly or is altered through defence mechanisms; it appears as a symptom, such as an obsession, a compulsion, a phobia, or a sexual dysfunction. Although not used in DSM-IV, many clinicians consider the following diagnostic categories as neuroses: anxiety disorders, somatoform disorders, dissociative disorders, sexual disor-

ders, and dysthymic disorder. The term 'neurosis' signifies that the person's gross reality testing and personality organization are intact though the person is impaired in a number of areas.[3]

4. Development of the Diagnostic and Statistical Manual System[4]

The need for a classification of mental disorders has been clear throughout the history of medicine. However there has been little agreement on which disorders should be included and the optimal method for their organization. Many nomenclatures have been developed during the past two millennia, but they differ in their respective emphasis on phenomenology, aetiology and course as defining features. Some systems have included only a handful of diagnostic categories while others have included hundreds. Besides, the various systems for categorizing mental disorders differed depending on whether their principal objective was for use in clinical, research, or statistical settings. In the United States, the initial impetus for developing a classification of mental disorders was the need to collect statistical information.

The official classification of mental disorders came into existence in USA in the census of 1840 with a one-item classification scheme. 'Idiocy (insanity)' was the single category used to classify mental illness. Later in the census of 1880 eight categories of mental illnesses were mentioned. Side by side, the World Health Organization (WHO) had its own classification of mental illnesses called the International Classification of Diseases (ICD). Both the International Classification of Diseases (ICD) by the World Health Organization and the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association continued to revise the classification till now. By now we have the 10th edition of the classification of mental disorders by ICD and the 4th edition of DSM. The history of their development is as follows:

The American Psychiatric Association (APA) published the first version of the diagnostic manual in 1952 and it was called at that time 'Diagnostic and Statistical Manual: Mental Disorders.' The merit of this version was that it provided descriptions for the mental disorder categories it listed out. Thus we had the DSM-I. An attempt was made to bring out a new edition of DSM-I to

coincide with the eighth revision of the World Health Organization's International Classification of Diseases which came out in 1969. DSM-II was published one year prior to the publication of ICD-8, that is in 1968.

The ICD-9 came into effect in 1979. The Task Force on Nomenclature and Statistics that worked on DSM-III had been working with the task force of ICD-9 and published DSM-III in 1980; later a revision was brought out in 1987 as DSM-III-R. Though the task force responsible for DSM-III wanted to fall in line with ICD-9, there was concern that the ICD-9 classification and glossary would not be suitable in the USA for clinical and research use.

Meanwhile, a major revolution had taken place in psychiatry with the development of the diagnostic criteria. The concept of diagnostic criteria was introduced to psychiatry in the 1970s; in 1972 Feighner criteria covering 16 diagnostic categories were identified. These were revised and expanded into the Research Diagnostic Criteria (RDC) in 1978 covering 21 categories. DSM-III achieved the herculean task of creating specified criteria for over 150 categories. DSM-III was widely accepted in the USA as the common language of mental health clinicians and researchers for communicating about the disorders for which they had the professional responsibility. All major textbooks of psychiatry and psychopathology made extensive reference to it. Though it was primarily meant for use in the United States of America, it had considerable influence internationally. Besides, many of its basic features like specified diagnostic criteria, were adopted for inclusion in the mental disorders chapter of ICD-10 (1992) of the World Health Organization. ICD-10 is the official classification system used in Europe. All the categories used in DSM-IV are found in ICD-10, but not all ICD-10 categories are in DSM-IV.

Need for changes in the DSM-III definitions had arisen as experience with the criteria had revealed many instances in which they were not entirely clear, were inconsistent across diagnostic categories, or were even contradictory. And so work on DSM-III-R was begun in 1983, just three years after the publication of DSM-III. In the year 1987 DSM-III-R was published.

As the work began on ICD-10, the president of the American Psychiatric Association appointed Dr. Allen Frances to chair the development of DSM-IV. In the year 1988, Dr. Allan Frances selected the new task force, made up of 25 individuals. There were also 13 work groups, each with five to eight members, who consulted an extensive list of advisors and consultants both in USA and abroad. Three major phases marked the development of DSM-IV. First of all each work group developed comprehensive literature reviews bearing on controversial issues in its area of focus and considered the recent scientific findings that might suggest changes in the classification, text, or criteria of mental disorders. Secondly the John D. and Catherine T. MacArthur Foundation funded a series of analyses of data from studies that had already been completed or were in progress, to answer specific nosological questions. Thirdly, 12 field trials were funded by the National Institute of Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), to study the impact of changes that were being considered for inclusion in DSM-IV. Thus came into existence DSM-IV in 1994.

5. Coding and Reporting Procedures[5]

The official coding system in use in the USA as of publication of DSM-IV is the international Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). Most DSM-IV disorders have a numerical ICD-9-CM code. The use of diagnostic codes is fundamental to medical record, data collection and retrieval and compilation of statistical information and to report diagnostic data to interested third parties like governmental agencies, private insurers, and the World Health Organization. Subtypes (some of which are coded in the fifth digit) and specifiers are provided for increased specificity. Subtypes define mutually exclusive and jointly exhaustive pheonomenological subgroupings within a diagnosis. In contrast, specifiers are not intended to be mutually exclusive or jointly exhaustive. Specifiers provide an opportunity to define a more homogeneous subgroup of individuals with the disorder who share certain features. Although a fifth digit is sometimes assigned to code a subtype or specifier or severity, the majority of subtypes and specifiers included in DSM-IV

cannot be coded within the ICD-9-CM system. In this book I have given the code numbers of both DSM-IV and ICD-10.

In the book 'NOS' will mean Not Otherwise Specified. An x appearing in a diagnostic code indicates that a specific code number is required. An ellipsis (…) indicates that the name of a specific mental disorder or general medical condition should be recorded by the psychiatrist.

6. Severity and Course Specifiers[6]

A DSM-IV diagnosis is usually applied to the individual's current presentation and is not typically used to denote previous diagnoses from which the individual has recovered. Severity and course are indicated by the use of the terms like mild, moderate, severe, in partial remission, in full remission, and prior history.

Mild : Few, if any, symptoms in excess of those required to make the diagnosis are present, and symptoms result in no more than minor impairment in social or occupational functioning.

Moderate: Symptoms or functional impairment between mild and severe are present.

Severe: Many symptoms in excess of those required to make the diagnosis, or several symptoms that are particularly severe, are present, or the symptoms result in marked impairment in social or occupational functioning.

In Partial Remission: The full criteria for the disorder were previously met, but currently only some of the symptoms and signs of the disorder remain.

In Full Remission: There are no longer any symptoms or signs of the disorder but it is still clinically relevant to note the disorder.

Prior History: For some purposes, it may be useful to note a history of the criteria having been met for a disorder even when the individual is considered to be recovered from it.

7. Not Otherwise Specified Categories[7]

Because of the diversity of clinical presentations, it is impossible in the diagnostic nomenclature to cover every possible situa-

tion. In that case those items are listed as Not Otherwise Specified (NOS). There are four situations in which an NOS diagnosis may be appropriate. 1) The presentation conforms to the general guidelines for a mental disorder in the diagnostic class but the symptomatic picture does not meet the criteria for any of the specific disorders (as in the case of symptoms below the diagnostic threshold or there is a mixed presentation). 2) The presentation conforms to a symptom pattern that has not been included to the DSM-IV classification but that causes clinically significant distress or impairment. 3) There is uncertainty about aetiology (i.e., whether the disorder is due to a general medical condition, is substance induced, or is primary). 4) There is insufficient opportunity for complete data collection or inconsistent or contradictory information, but there is enough information to place it within a particular diagnostic class.

8. Multiaxial Assessment[8]

Multiaxial system involves an assessment on several axes, each of which refers to a different domain of information that may help the clinician plan treatment and predict outcome. There are altogether five axes used in DSM-IV.

Axis I: Axis I contains Clinical Disorders and Other Conditions That May Be a Focus of Clinical Attention. Axis II: Axis II contains Personality Disorders and Mental Retardation. Axis III: Axis III lists any physical disorder or general medical condition that is present in addition to the mental disorder (General Medical Condition). Axis IV: Psychosocial and Environmental problems. Axis V: Global Assessment of Functioning. This is for reporting the clinician's judgement of the individual's overall level of functioning. This information is useful in planning treatment and measuring its impact, and in predicting outcome. This can be done using the Global Assessment of Functioning (GAF) Scale and is useful in tracking the clinical progress of individuals in global terms, using a single measure. It considers psychological, social and occupational functioning on a hypothetical continuum of mental health-illness and does not include impairment in functioning due to physical (or environmental) limitations.

I intend to treat only the first two axes, since the other three may not be that essential for a psychological counsellor though the knowledge of them would be highly beneficial for him/her.

9. Mental Status Examination

The mental status examination is a description of all the areas of mental functioning of the patient. Psychiatrists follow a structured format in recording their findings. These descriptive data are then used to support the psychiatrists' diagnostic conclusions.[9]

1) General Description[10]

(1) Appearance

This includes the prominent physical features of an individual and highlights his/her unique aspects. They are facial features; hair colour, texture, styling, and grooming; height; weight; body shape; cleanliness; neatness; posture; bearing; clothing; jewellery; skin texture, scars, and tattoos; level of eye contact; eye movements; facial expressions and mobility; tearfulness; degree of friendliness; and an estimate of how old the patient looks compared with chronological age.

(2) Motor Behaviour

This includes the patient's gait and freedom of movement, and noting the firmness and strength of handshake. The psychiatrist observes any involuntary or abnormal movements such as tremors, tics, mannerisms, lip smacking, akathisias, or repeated stereotyped movements. Comments on the purposefulness of movements and the degrees of agitation of the patient as reflected in pacing and hand wringing are noted.

(3) Speech

The rate of speech, the spontaneity of verbalizations, the range of voice intonation patterns, the volume in terms of loudness, defects in verbalizations such as stammering or stuttering, and any aphasias are to be noted.

(4) Attitudes

How the patient related to the interviewer, the general impression as 'friendly and cooperative,' focus on any shifts or changes in attitude during particular points in the interview are to be noted.

2) Emotions[11]

(1) Mood

Mood is the sustained feeling tone that prevails over time for a patient. At times the patient will verbalize this mood, and at other times the psychiatrist will have to enquire about it and even infer the patient's mood from observations of the patient's nonverbal body language. When describing, it is necessary to record how deeply it is felt, the length of time that it prevails, and how much it fluctuates. Anxious, panicky, terrified, sad, depressed, angry, enraged, euphoric, and guilty are the moods frequently described.

(2) Affective Expression

The range of expression of feeling tones is observed and recorded. The predominant expression is described which includes flat affect, in which there is virtually no visible expression of feelings during the relating of emotionally charged material. This mode of expression has been classically associated with schizophrenia. The incongruity of the expressions with the verbalizations is most striking in schizophrenia and other psychotic disorders. Constricted affects are often seen with depression. Lability (alternation between euphoria and irritability) of mood may be associated with cognitive disorders, and blunting of affects is often seen with dementia. The patient's nonverbal behaviours, such as facial mobility, voice intonation patterns, and body movements are noted to assess affective expression.

(3) Appropriateness

Are the affective tone and the expression appropriate to the subject matter being discussed in the context of the patient's thinking? Disharmony between affective expression and thought content needs to be explored, and noted down.

3) Perceptual Disturbances

(1) Hallucinations and Illusions

A hallucination is a perceptual distortion that a patient experiences for which there is no external stimulus. These hallucinations may be auditory (hearing noises or voices that nobody else hears), visual (seeing objects that are not present), tactile (feeling

sensations when there is no stimulus for them), or olfactory (smelling odours that are not present). Hallucinations during the hypnagogic state (the drowsy state preceding sleep) and the hypnopompic state (the semiconscious state preceding awakening) are experiences associated with normal sleep and with narcolepsy. An illusion is a false impression that results from a real stimulus. Perceiving a rope in the dark as a snake is an example of illusion.

(2) Depersonalisation & Derealization

'Depersonalisation' describes patients' feelings that they are not themselves, that they are strange, or that there is something different about themselves that they cannot account for. The symptom is associated with a variety of psychiatric disorders. 'Derealization' expresses patients' feeling that the environment is somehow different or strange but they cannot account for these changes. This perceptual distortion is frequently seen in schizophrenic patients.[12]

4) Thought Process

One notices how well a patient formulates, organizes and expresses his thoughts. Coherent thought is clear, easy to follow, and logical. A formal thought disorder includes all disorders of thinking that affect language, communication of thought, or thought content. This disorder is found in schizophrenic patients.

(1) Stream of Thought

Here one notices the quantity and rate of the patient's thoughts. One looks for the two extremes, whether there is a paucity or a flooding of thoughts. Also one needs to note whether there is retardation or slowing, or whether there is acceleration or racing. When thoughts are so sped up that one has difficulty keeping up with the patient, it is termed as a 'flight of ideas.' One also notices the goal directedness and continuity of the patient's thoughts. Disturbances include circumstantiality, tangential thinking, blocking, loose associations, and perseveration. 'Circumstantiality' is a disorder of associations in which the patient exhibits lack of goal directedness, incorporates tedious and unnecessary details, and has difficulty in arriving at an end point. 'Tangentiality' describes a thought process in which the patient digresses from the subject under discussion and introduces thoughts that seem

unrelated, oblique, and irrelevant. 'Blocking' is a sudden cessation in the middle of a sentence, at which point a patient cannot remember what he/she has said or complete his/her thoughts. 'Loose associations' refers to a jumping from one topic to another with no apparent connection between the topics. 'Perseveration' refers to the patient's repeating the same response to a variety of questions and topics, with an inability to change his/her response or to change the topic.

Marked abnormalities of thought processes include neologisms, word salad, clang associations, and echolalia. A 'neologism' is a word that a patient makes up – often a condensation of several words that is unintelligible to another person. 'Word salad' is an incomprehensible mixing of meaningless words and phrases. In 'clang associations,' the connections between thoughts may be tenuous, and the patient uses rhyming and punning. 'Echolalia' describes a patient's irrelevant parroting of what another person has said.[13]

(2) Thought Content (Delusions, Obsessions, Compulsions, Preoccupations, Phobias)

'Thought content' refers to what the patient talks about. There are specific areas that the psychiatrist inquires about if they are not brought up by the patient. One important area is whether the patient has suicidal thoughts. This is particularly required in patients who signal feelings of helplessness, hopelessness, worthlessness, or giving up.

'Delusions' are false fixed beliefs that have no rational basis in reality and are deemed unacceptable in the patient's culture. Delusions that cannot be understood by other psychological processes are referred to as 'primary delusions.' Some examples for this are thought insertion, thought broadcasting, and beliefs about world destruction. 'Secondary delusions' are based on other psychological experiences. These include delusions derived from hallucinations, other delusions, and morbid affective states. These types of delusions include those of persecution, of jealousy, of guilt, of love, of poverty, and of nihilism. In addition to the description of delusions, one should also note the degrees of organization of the delusion. One should also note if there are ideas of reference and ideas of influence.

One notices any 'obsessions' the patients may have. These are marked by repetitive, unwelcome, irrational thoughts that impose themselves on the patient's consciousness and over which he/she has no apparent control. These thoughts are accompanied by feelings of anxious dread and are ego-alien, unacceptable, and undesirable. They are strongly resisted by the patient.

'Compulsions,' a closely parallel phenomenon to the obsessions, are repetitive, stereotyped behaviours that the patient feels impelled to perform ritualistically, even though he/she recognizes the irrationality and absurdity of the behaviours. Although no pleasure is derived from performing such an act, there is a temporary sense of relief of tension when it is completed. The degree of interference by obsession and compulsion with the patient's functioning has to be noted.

'Preoccupations' reflect the patient's absorption with his/her own thoughts to such a degree that the patient loses contact with external reality. Mild forms of preoccupations are reflected in absentmindedness; severe form can involve suicidal or homicidal ideation and the autistic thinking of the schizophrenic patient.

'Phobias' are morbid fears that are reflected by morbid anxiety. Even if they are not spontaneously conveyed in the interview, one should make specific enquiries about their presence.[14]

(3) Abstract Thinking

Abstract, or categorical, thinking is formed late in the development of thought and reflects the capacity to formulate concepts and to generalize. Several methods are used to test this capacity. These include testing similarities, differences, and the meaning of proverbs. The inability to abstract is referred to as concreteness, which in turn reflects an earlier childhood development of thought. Concreteness of responses on formal testing reflects intellectual impoverishment, cultural deprivation, and cognitive disorders such as dementia. Bizarre and inappropriate responses to proverbs reflect schizophrenic thinking.

An example of testing for similarities in the patient would be like this: Counsellor: How are a mango and a banana alike? Patient: They are both fruits. The answer reflects the capacity to abstract. Patient: Pluck them from the trees. It is a form of concreteness. A bizarre response would be: Mango market going banana leaves. In the same way one could test the patient for the

meaning of a proverb. Counsellor: Give the meaning of 'All that glitters is not gold.' Patient: Appearances are deceptive. The patient has the capacity to abstract. Patient: Appearances, you know, you know. It is a concrete response. Patient: Appearances appearances go and come back. It is an inappropriate response.[15]

(4) Education and Intelligence

Intelligence is best measured in the clinical interview by the patient's use of vocabulary. The expectations of levels of intelligence are influenced by the level of education of the patient. If for example a patient who did only his primary education exhibits an advanced vocabulary, the counsellor concludes that the patient's intelligence exceeds his/her scholastic achievement. Specific testing for intelligence is used only when deficits are implied on the basis of the interview.[16]

(5) Concentration

Concentration reflects the patient's ability to focus and to maintain his/her attention on a task. In the interview, troubles with concentration are reflected in the patient's inability to pay attention to the questions that he/she is being asked. The patient may be distracted by external or internal stimuli. When the patient's concentration is impaired, the psychiatrist often has to repeat the questions.

Formal testing for concentration includes serial 7s, in which the patient is asked to subtract 7 from 100 and keep subtracting 7 from each answer. If the patient has cognitive difficulties performing serial 7s, serial 3s or counting backward from 20 can be substituted. The counsellor can devise other methods of checking with numbers. Immediate recall and concentration abilities often overlap. One way to test for immediate recall is to ask the patient to repeat digits forward and backward.

The patient is instructed to repeat the numbers recited by the counsellor. The counsellor recites a three digits number with 1 second apart and asks the patient to repeat them. The counsellor can go on like this adding one digit at a time until he is able to assess how many digits the patient can repeat. The same exercise is conducted with repeating the digits backward. Thus the counsellor records how many numbers the patient can recite backward.[17]

(6) Orientation (Time, Place, Person, Situation)

Orientation reflects patients' capacities to know who they are, where they are, what date and time it is, and what their present circumstances are. Patients who have deficits in these spheres are commonly suffering from cognitive disorders. Testing for time includes asking the patient the month, the date of the month, the year, the day of the week, and the time of day and the season of the year. Orientation to place includes the patient's knowing the name of the place where he/she is currently located and the name of the city and state. Orientation to person includes the patient's knowing his/her own name and the names and roles of persons in his or her immediate surroundings. Orientation to situation indicates the patient's present circumstances and why he or she finds himself/herself in such circumstances. This is often an important clue toward the competency of individuals to give informed consent. In reversible cognitive disorders (e.g., delirium), the patient first reorients to person, then to place, and lastly to time. The counsellor could ask: Do you know what today's date is? The month? The year?[18]

5) Memory[19]

(1) Remote Memory

Remote memory is the recollection of events from earlier in life. The counsellor tests for this function by asking where the patient grew up. Where he/she went to school, and what his/her first job was; and inquires about significant people from the past (e.g., naming of presidents, prime ministers) and also significant events (e.g., World War I & II).

(2) Recent Past Memory

Recent past memory refers to recalling verifiable events from the past few days. To test for this, the counsellor inquires about what the patient ate for breakfast or what he/she read in the newspaper or asks for details about what the patient watched on television the night before.

(3) Recent Memory

Recent or short-term memory is gauged by the patient's capacity to recount what he/she was told 5 minutes after hearing

and being coached to remember it. The counsellor tests this capacity by asking the patient to repeat the names of three unrelated objects, and then informing him/her that they will go on to discuss other subjects and that in 5 minutes the patient will be asked to name the three objects.

6) Impulse Control

Impulse control is 'the ability to control the expression of aggressive, hostile, fearful, guilty, affectionate, or sexual impulses in situations where their expression whould be maladaptive.' Manifestations of this phenomenon are verbal and/or behavioural. A loss of control can reflect a low frustration tolerance.[20]

7) Judgement

Judgement refers to the patient's capacity to make appropriate decisions and appropriately act on them in social situations. An assessment of this function is best made in the course of obtaining the patient's history. There is no necessary correlation between intelligence and judgement. Formal testing is rarely helpful. The counsellor could ask the patient like this: What would you do if you saw a child drowning in a pond?[21]

8) Insight

The capacity of the patient to be aware and to understand that he or she has a problem or illness and to be able to review its probable causes and arrive at tenable solutions is referred to as insight. Emotional insight refers to the patient's awareness of his/her motivations, and, in turn, his/her feelings, so that the patient can change longstanding, ingrained patterns of behaviour. Self-observation alone is insufficient for insight. Emotional insight must be applied for the change to occur.[22]

9) Reliability

The counsellor, upon completion of an interview, assesses the reliability of the information that has been obtained. Factors affecting reliability include the patient's intellectual endowment, his/her honesty and motivations, the presence of psychosis or organic defects, and the patient's tendency to magnify or understate his/her problems.[23]

If a counsellor or a therapist is ignorant of the various types of mental illness, he/she is functionally less effective. By knowing about mental illnesses one knows one's boundary and can easily make a referral without further delay, which is essential for the clients. This is the main reason for my writing this book. I have attempted to describe the illnesses at great length, though I have not gone into great details with regard to 'Mental disorders due to a general medical condition,' 'Substance related disorders' and 'Other conditions that may be a focus of clinical attention.' I feel that these are not very much needed for a counsellor or a psychotherapist. Once the counsellor identifies the disorder he/she can refer the matter to the psychiatrist and then follow-up with counselling or psychotherapy. Wherever possible I have indicated the types of psychotherapies that are useful to deal with a particular issue. Hope your reading will enrich you with knowledge and stimulate you to further reading and more effective counselling.

1

PERSONALITY DISORDERS

A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.

1. General Diagnostic Criteria for a Personality Disorder

General Diagnostic Criteria for a Personality Disorder

A. An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:
   (1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
   (2) affectivity (i.e., the range, intensity, lability, and appropriateness of emotional response)
   (3) interpersonal functioning
   (4) impulse control

B. The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The pattern is stable and of long duration and its onset can be traced back at least to adolescence or early adulthood.

E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.

F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., head trauma).

Personality Disorder Not Otherwise Specified: It is a category provided for two situations: 1) the individual's personality pattern meets the general criteria for a personality disorder and traits for several different personality disorders are present, but the criteria for any specific personality disorder are not met; 2) the individual's personality pattern meets the general criteria for a personality disorder, but the individual is considered to have a personality disorder that is not included in the classification.

It is estimated that personality disorders are relatively common in the general population, the prevalence being between 10% and 13%. Some patients intensely desire relationships but fearfully avoid them because they anticipate rejection; others seek endless admiration and are engrossed with grandiose fantasies of limitless power, brilliance, or ideal love. Still others have a self-concept so disturbed that they feel they embody evil or do not exist.[1]

2. History of Personality Disorders

Personality types and disorders have been described for thousands of years. Hyppocrates described four temperaments: pessimistic melancholic, the overly optimistic sanguine, the irritable choleric, and the apathetic phlegmatic. The early Greeks' theory that these four temperaments were determined by the relative proportion of the four bodily humors (black bile, blood, yellow bile, and phlegm, respectively) is reflected in current attempts to discover biogenetic bases of personality.

In the early 1800s, psychiatrists such as Pinel, Esquirol, Rush, and Pritehard described socially maladaptive personality types. At the turn of the century Janet and Freud described more specific personality types and described the psychological traits associated with hysteria, the forerunner of histrionic personality disorders. Later, within the framework of early psychoanalytic instinct theory, Abraham proposed that arrests at the three psychosexual stages of childhood development – the oral, anal, and phallic phases – led to the development of the dependent, obsessive-compulsive, and hysterical character types, respectively. These theories changed as the early instinct theory and the subsequent ego-psychological model of psychoanalytic theory were gradually supplanted by the object relations theory, which proposes that personality is shaped

largely by the child's early parental relationships. According to this framework, the dependent personality traits derive from parental deprivation; the obsessive-compulsive traits from control struggles with parental figures; and the hysterical traits, in part, from parental seduction and competition. The borderline and the narcissistic personality disorders too have their base in the object relations theory.

A new perspective dawned in the field of psychiatry in the 1920s. The German phenomenologists Kraepelin (1921) and Kretschmer (1925) described personality types in terms of the 'spectrum concept' – the theory that personality types are biogenetically related variants of the paranoid and affective psychoses. This theory is the forerunner of the current paranoid, schizotypal, cyclothmic, and depressive personality disorders.

In contrast to the spectrum concept, the German phenomenologist Schneider (1958) considered personality disorders to represent socially deviant and extreme variants of normally occurring personality traits. He developed the first comprehensive system of personality disorder categories. This provided the template for many of those contained in the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) (World Health Organization 1992) and the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (the American Psychiatric Association 1994). Personality disorders have been included in every version of DSM but only the paranoid, obsessive-compulsive, and antisocial personality disorders have been consistently mentioned in all the versions.[2]

3. Classification Issues

Since DSM-III, the personality disorders have been grouped into three clusters: 1) the odd or eccentric cluster (schizotypal, schizoid, and paranoid); 2) the dramatic, emotional, or erratic cluster (borderline, histrionic, narcissistic, and antisocial); and 3) the anxious or fearful cluster (avoidant, dependent, and obsessive-compulsive). This grouping has its own limitation since it is done on the similarities of description rather than on aetiology. Moreover, individuals frequently present with co-occurring Personality Disorders from different clusters.

Another classification issue is whether the personality disorders are best classified as dimensions or categories. Do personality disorders exist along dimensions that reflect extreme variants of normal personality? Or, are they distinct categories that are qualitatively different, and are clearly demarcated, from normal personality traits and one another? The dimensional model may more comprehensively cover problematic traits. The categorical model works in terms of pathological syndromes that a person either has or does not have. DSM-IV is based primarily on the categorical model, yet it incorporates a dimensional approach to some extent, in that it encourages clinicians to identify problematic personality traits that are at a subthreshold level for any particular diagnosis.

Assessment of a personality disorder should rule out the possibility that what appear to be personality traits are not symptoms of a medical illness. For example, aggressive outbursts caused by seizure disorder should not be attributed to borderline or antisocial personality disorder. Therefore a medical evaluation should precede the psychological assessment.

Assessment should make sure that personality disorder-features are pervasive – that is, not limited to only one situation or occurring in response to only one specific trigger: these features should be enduring rather than transient. Research indicates that existing personality disorder criteria are relatively free of sex bias. Since the personality of children and adolescents is still developing, personality disorders should be diagnosed with care. It is better to defer the assessment until late adolescence or early adulthood at which time a personality disorder diagnosis may be appropriate if the features appear to be pervasive, stable, and likely to be enduring.

4. Summary of Personality Disorder Features[3]

Cluster	Model	Key Clinical Features	Treatment	Course/ Prognosis
A Odd, Eccentric. Schizotypal, Schizoid, & Paranoid	Spectrum disorders	Social deficits, absence of close relationships	Structure, rehabilitation, support, medication	Stable/poor

B Dramatic, emotional, erratic. Borderline, Histrionic, Narcissistic, & Antisocial	Self disorders	Social & interpersonal instability	Support, exploration, sociotherapy, medication	Unstable/ some remission with age
C Anxious, fearful. Avoidant, Dependent& Obsessive-compulsive	Dimensional disorders	Interpersonal and intrapsychic conflicts	Exploration, individual therapy, group therapy	Modifiable/ good

5. Aetiology and Pathogenesis

What causes personality disorders is an intriguing question. Various hypotheses have been formulated over the years. Some views tended to emphasize the contribution of developmental and environmental factors (pathological or inadequate parenting). However constitutional or biological factors have also been postulated to play an important role in the aetiology of personality disorders. Recent researches indicate that personality disorders (as well as normal personality traits) result from a complex combination of, and interaction between, temperament (genetic and other biological factors) and psychological (developmental or environmental) factors. These factors seem to be important to all of these disorders, although the degree to which these factors contribute to aetiology appears to vary for the different personality disorders. For example, antisocial personality disorder has a significant genetic component. Likewise, the schizotypal personality disorder has a substantial degree of heritability, and is genetically linked to schizophrenia. But, for the borderline personality disorder, the impact of environmental (i.e., developmental) experiences appear to be more important, even though there is some evidence for a genetic component. Not much of investigation is done with regard to the cluster C disorder. Recent researches indicate that half

the observed variance in personality traits such as neuroticism, introversion, and submissiveness can be traced to genetic variation.

There is also some evidence for the underlying neurobiology of these disorders. Neurobiological abnormalities are noted in persons with schizotypal personality disorder; alterations in brain structure and function have been related to deficit-like symptoms and increased dopaminergic function to psychotic-like symptoms. Abnormalities in the serotonin system, which appear to mediate behavioural inhibition, have been found in individuals with borderline and antisocial personality disorders.

Environmental antecedents of personality disorders such as family environment and sexual and physical abuse seem to be linked to borderline personality disorder.[4]

6. Treatment[5]

Personality disorders consist of deeply ingrained attitudes and behaviour patterns that consolidate during development and have endured since childhood and therefore it is difficult to change them. The individuals with the personality disorders themselves may not consider the disorders as undesirable and related to their problems.

The psychoanalysts attempted to address the issue of treatment. Originally, neurosis was considered a discrete set of symptoms related to a discrete developmental phase or to discrete conflicts. This view was later replaced by the idea that more enduring defensive styles and identification processes were the building blocks of character traits. Thus came into existence the concept of character analysis and defence analysis by Wilhelm Reich (1940) and others. Side by side, a development in technique evolved from group therapy experience. Maxwell Jones (1953) emphasized the importance of confrontations given within group settings in which peer pressure made it difficult for the individuals to ignore the feedback or to leave the group. This general principle was adopted by other forms of sociotherapies.

The use of pharmacotherapy for personality disorders is in progress. Impulsiveness and aggression may respond to serotonergic medications; mood instability and lability may respond to serotonergic medications and to other antidepressants; and psychotic-like experiences may respond to neuroleptics.

Recently, cognitive-behavioural therapies are used more and more in treating personality disorders. Cognitive strategies involve identifying the specific internal mental schemes by which patients typically misunderstand certain situations or misrepresent themselves, and then learning how to modify those internal schemes.

Personality Type	Psychotherapies	Sociotherapies	Pharmacotherapies
1.Schizotypal	No Support	Uncertain support	Modestly helpful
2.Schizoid	Modestly helpful	Modestly helpful	No Support
3.Paranoid	No support	No support	Uncertain support
4.Borderline	Modestly helpful	Significantly helpful	Modestly helpful
5.Antisocial	No support	Modestly Helpful	No support
6.Histrionic	Significantly helpful	No support	No support
7.Narcissistic	Significantly helpful	No support	No support
8.Obsessive-compulsive	Significantly helpful	No support	No support
9.Dependent	Significantly helpful	Modestly helpful	No support
10.Avoidant	Significantly helpful	Modestly helpful	Uncertain support

SECTION - I

7. Cluster A Personality Disorder

1) Paranoid Personality Disorder

(DSM-IV Code: 301.0 & ICD-10 Code: F60.0)

Paranoid personality disorder has been consistently represented in most descriptive psychiatric literature. It was referred to

as the 'pseudoquerulent type' and the 'fanatic psychopath' by Mayer, Koch, Kraepelin, Bleuler, Kretschmmer, and Schneider. Its description has always been focused on the disorder's central feature of a pervasive and unwarranted mistrust of others.

(1) Diagnostic Criteria[6]

Diagnostic Criteria for Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts as indicated by four (or more) of the following:

(1) suspects, without sufficient basis, that others are exploiting, harming, or deceiving him/her

(2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates

(3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him/her

(4) reads hidden demeaning or threatening meanings into benign remarks or events

(5) persistently bears grudges, i.e., is unforgiving of insults, injuries, or slights

(6) perceives attacks on his/her character or reputation that are not apparent to others, and is quick to react angrily or to counterattack

(7) has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, it has to be understood as 'Premorbid' as for example: Paranoid Personality Disorder (Premorbid) which will mean that the individual before the onset of schizophrenia had the history of paranoid personality disorder.

Individuals with paranoid personality disorder have a pervasive, persistent, and inappropriate mistrust of others. They are suspicious of others' motives and assume that others intend to harm, exploit, or trick them. They usually question, without justification, the loyalty or trustworthiness of friends or sexual partners. They are reluctant to confide in others for fear the information they provide will be used against them. They appear guarded, tense, and hypervigilant, and they constantly scan their environment for clues of possible attack, deception, or betrayal. Often they find evidence of malevolence by misinterpreting benign events. In response to perceived or actual insults or betrayals, they overreact, quickly becoming excessively angry and responding with counterattacking behaviour. Besides, they find it difficult to forgive or forget the wrong they think are done to them and they harbour long-term grudges against the supposed betrayers, and at times they are litigious. While some of them may appear quietly and tensely aloof and hostile, others are overtly angry and combative. Needless to say that they are usually socially isolated and have difficulties with co-workers.

I know a man who thinks that all his letters are censored and someone really steals them from the post office. He was suspecting every member who lived with him for this particular supposed violation of his right to privacy.

(2) Differential Diagnosis[7]

In Common with	Characteristics Shared	Exclusively characteristic of Paranoid Personality Disorder or of the disorder with which it is compared or difference between the two disorders
Delusional disorder, persecutory type, Schizophrenia, paranoid type, Mood Disorder with psychotic features	Suspiciousness	All of these have a period of persistent psychotic symptoms (e.g., delusions and hallucinations) which paranoid personality does not have

Schizotypal Personality Disorder	Suspiciousness, interpersonal aloofness, and paranoid ideation	Schizotypal – also includes symptoms such as magical thinking, unusual perceptual experiences, and odd thinking and speech.
Schizoid Personality Disorder	Appear strange, eccentric, cold, and aloof	Schizoid – does not have paranoid ideation
Borderline and Histrionic Personality Disorders	React to minor stimuli with anger	Borderline and histrionic – do not have pervasive suspiciousness
Avoidant Personality Disorder	Reluctant to confide in others	Paranoid – motive for reluctance is fear of others' malicious intent; Avoidant – out of fear of being embarrassed or found inadequate
Antisocial Personality Disorder	Antisocial behaviour	Paranoid – due to a desire for revenge; Antisocial–due to a desire for personal gain or to exploit others
Narcissistic Personality Disorder	Suspiciousness, social withdrawal, or alienation	Narcissistic – due to fears of having their imperfections or flaws revealed

(3) Aetiology

Early psychoanalytic speculation suggested that Paranoid Personality Disorder was the result of reaction formation against and projection onto others of homosexual impulses; but this theory is not tenable. All the same the defence mechanism of projection is generally assumed to be involved in it. Some suggest that it springs from being the object of excessive parental rage. Some others suggest that it is due to the experience of being humiliated especially by the members of the same sex. It is likely that this type has biogenetic contributions. At present it is understood that this type is due to both environmental and constitutional factors in its aetiology.[8]

(4) Treatment

Because these patients mistrust others, they usually avoid psychiatric treatment. When they approach treatment, they are to be extremely respected with a straightforward and unintrusive style aimed at building trust. It is better to offer a straightforward apology when found fault with rather than respond evasively or defensively. Again it is not necessary to maintain an overly warm style, because excessive warmth and expression of interest can exacerbate patient's paranoid tendencies. A supportive psychotherapy that incorporates the above tips may be the best treatment for these patients. Group treatment or cognitive-behavioural treatment aimed at anxiety management and the development of social skills might be useful. But, they tend to resist this due to suspiciousness and fear of losing control and being criticized.[9]

2) Schizoid Personality Disorder

(DSM-IV Code: 301.20 & ICD-10 Code: F60.1)

Schizoid personality disorder was originally considered as the personality type associated with schizophrenia – a role that is now greatly assumed by schizotypal personality disorder. It was described as 'shut-in personality,' 'schizoidie,' and 'autistic personality.' A similar personality type was also described in the psychoanalytic literature by object relations theorists Fairbairn and Guntrip. They used the term in a broader fashion to describe socially withdrawn patients who had difficulties with intimacy. Broadly defined in DSM-I and DSM-II, the category was later divided into the schizoid, avoidant and schizotypal personality disorders.

(1) Diagnostic Criteria

Diagnostic Criteria for Schizoid Personality Disorder

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) neither desires nor enjoys close relationships, including being part of a family

(2) almost always chooses solitary activities

(3) has little, if any, interest in having sexual experiences with another person

(4) takes pleasure in few, if any, activities

(5) lacks close friends or confidants other than first degree relatives

(6) appears indifferent to the praise or criticism of others

(7) shows emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, another Psychotic Disorder or a Pervasive Developmental Disorder and is not due to the direct physiological effects of a general medical condition.

Note: If criteria are met prior to the onset of Schizophrenia, it has to be understood as 'Premorbid' as for example: Schizoid Personality Disorder (Premorbid) which will mean that the individual before the onset of schizophrenia had the history of schizoid personality disorder.

Schizoid personality disorder is characterized by a profound inability to relate to others in a meaningful way. Since they have no desire for relationships with others, they are socially extremely isolated. They may prefer to engage in solitary, intellectual activities and may create an elaborate fantasy world into which they retreat and which substitutes for relationships with others. They may seldom marry, and often work at jobs requiring little interpersonal interaction like work in a laboratory. They are also marked by lack of affect. They appear cold, detached, aloof, and constricted and have particular discomfort when experiencing warm feelings. They suffer from chronic anhedonia. They seem indifferent to the approval or criticism of others and do not appear to be bothered by what others may think of them. They may not be aware of the normal subtleties of social interaction and may not respond appropriately to social cues. They show a bland exterior without visible emotional reactivity and rarely appropriate gestures or facial expression. They rarely have experience of strong emotions such as anger and joy. If obliged to have social interactions, they seem to experience painful feelings. Even when provoked, they have difficulty in expressing anger. They may do well when they

work under conditions of social isolation. In response to stress, they may experience brief psychotic episodes. This condition may appear as the premorbid antecedent of Delusional Disorder or Schizophrenia. They may also develop Major Depressive Disorder. Most often it may co-occur with Schizotypal, Paranoid, and Avoidant Personality Disorders.

This disorder may first appear in childhood and adolescence with solitariness, poor peer relationships, and underachievement in school. This is diagnosed slightly more often in males. It may have increased prevalence in the relatives of individuals with Schizophrenia or Schizotypal Personality Disorder.

Sometimes cultural influences may be mistakenly understood as schizoid, as for example those who move from a rural to an urban environment or the immigrants who may appear to be socially isolated, emotionally constricted due to 'emotional freezing.' They are not schizoid.[10]

(2) Differential Diagnosis[11]

In Common with	Characteristics Shared	Exclusively characteristic of Schizoid Personality Disorder, or of the disorder with which it is compared or difference between the two disorders
Delusional Disorder; Schizophrenia; Mood Disorder with psychotic features	Detachment from social relationships; restricted range of emotional expressions	Delusional disorder, schizophrenia, mood disorder with psychotic features have a period of persistent psychotic symptoms (i.e., delusions and hallucinations).
Autistic Disorder; and Asperger's Disorder	Impaired social interaction	Autistic and Asperger's – are marked by more severely impaired social interaction and stereotyped behaviours and interests.
Schizotypal Personality Disorder	Social isolation, and restricted affectivity	Schizotypal – has cognitive and perceptual distortions which the schizoid does not have.
Paranoid Personality Disorder	Social isolation and restricted affectivity	Paranoid – has suspiciousness and paranoid ideation, which the schizoid does not have.
Avoidant Personality Disorder	Social detachment	Avoidant – due to fear of being embarrassed or found inadequate, and excessive anticipation of rejection.
Obsessive-Compulsive Personality Disorder	Social detachment	Obsessive-compulsive – may show an apparent social detachment stemming from devotion to work and discomfort with emotions, but unlike Schizoid have an underlying capacity for intimacy.

(3) Aetiology

Schizoid personality disorder occurs in adults who experienced cold, neglectful, and ungratifying relationships in early childhood, which lead these persons to assume that relationships are not valuable or worth pursuing. Some studies indicate an association of schizophrenia with the schizoid, and thus a genetic factor in its aetiology.[12]

(4) Treatment

Individuals with schizoid personality disorder rarely seek treatment, since they do not perceive any relationship including a therapeutic relationship as potentially valuable or beneficial. Some patients may tolerate supportive therapy aimed at the resolution of a crisis. Others may respond to insight-oriented psychotherapy aimed at effecting a basic shift in their comfort with intimacy and affects. The therapist should avoid early interpretation or confrontation. They may be coached to use inanimate bridges, such as writing and artistic productions to develop therapy relationship. Use of cognitive-behavioural therapies may be useful to encourage social involvement. Group therapies too facilitate the development of social skills and relationships.[13]

3) Schizotypal Personality Disorder

(DSM-IV Code: 301.22 & ICD-10 Code: F21)

Early concepts of schizotypal personality disorder were linked to schizophrenia. One of its forerunners is Bleuler's (1922) concept of latent schizophrenia, which consisted of mild or attenuated schizophrenia symptoms without deterioration into psychosis. The term 'schizotype' was coined by Rado (1956) and it denoted a nonpsychotic phenotypic variant of the schizophrenia genome. This term was later used as an alternative label for the 'borderline schizophrenia' syndrome identified in the Danish adoption studies, which was a milder schizophrenialike disorder present in the biological relatives of schizophrenic probands. Schizotypal personality disorder was new to DSM-III and was based on the characteristics of the relatives (i.e., the 'schizotypes') identified in the Danish adoption studies.

(1) Diagnostic Criteria

Diagnostic Criteria for Schizotypal Personality Disorder

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behaviour, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more)of the following:
   (1) ideas of reference (excluding delusions of reference)
   (2) odd beliefs or magical thinking that influences behaviour and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy, or 'sixth sense'; in children and adolescents, bizarre fantasies or preoccupations)
   (3) unusual perceptual experiences, including bodily illusions
   (4) odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped)
   (5) suspiciousness or paranoid ideation
   (6) inappropriate or constricted affect
   (7) behaviour or appearance that is odd, eccentric, or peculiar

   (8) lack of close friends or confidants other than first-degree relatives
   (9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgements about self

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder with Psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.

Note: If criteria are met prior to the onset of Schizophrenia, add as 'Premorbid,' e.g. 'Schizotypal Personality Disorder (Premorbid).'

Individuals with Schizotypal Personality Disorder often have ideas of reference (i.e., incorrect interpretations of casual incidents and external events as having particular and unusual meaning specifically for the person). These should be distinguished from delusions of reference, in which the beliefs are held with delusional conviction. They may be superstitious, or preoccupied with paranormal phenomena that are outside the norms of their subculture. They may feel that they have special powers to sense events before they happen or to read others' thoughts. They may believe that they have magical control over others, which can be implemented directly (e.g., believing that the gardener watering the plants is the direct result of their thinking) or indirectly through compliance with magical rituals (e.g., touching an object three times to avoid a certain harmful outcome). Perceptual alterations may be present (e.g., hearing a voice speaking one's name). Their speech is often loose, digressive, or vague, but without actual derailment or incoherence. They are often suspicious and may have paranoid ideation. They often appear to interact with others in an inappropriate, stiff, or constricted fashion. They have unusual mannerisms with an unkempt manner of dress. They experience acute discomfort in relating to others and are anxious in social situations.[14]

Schizotypal personality disorder occurs in approximately 3% of the general population. It has a stable course, with only a small proportion of individuals going on to develop Schizophrenia or another Psychotic Disorder. It seems to aggregate familially and is more prevalent among the first-degree biological relatives of the individuals with Schizophrenia.

(2) Differential Diagnosis[15]

In Common with	Characteristics Shared	Exclusively characteristic of Schizotypal Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Paranoid and Schizoid Personality Disorders	Social detachment and restricted affect	Schizotypal – has the presence of cognitive or perceptual distortions and is marked by eccentricity or oddness
Avoidant Personality Disorder	Social detachment	Schizotypal – there is a lack of desire for relationship; Avoidant – there is an active desire for relationships, but it is constrained by fear of rejection
Narcissistic Personality Disorder	Suspiciousness, social withdrawal, or alienation	Narcissistic – the motives are fears of having their imperfections or flaws revealed
Borderline Personality Disorder	Transient, psychotic-like symptoms	Schizotypal – have enduring psy chotic-like symptoms that may worsen under stress; Borderline – the symptoms are more closely related to affective shifts in response to stress (e.g., intense anger, anxiety, or disappointment) and are usually more dissociative (e.g., derealization or depersonalization)

Schizotypal personality disorder is distinguished from Delusional Disorder, Schizophrenia, and Mood Disorder with Psychotic Features as these three disorders have persistent psychotic symptoms of delusions and hallucinations.

(3) Aetiology

Schizotypal personality disorder is a schizophrenia-spectrum disorder – that is, it is related to schizophrenia. There is an increased risk for schizophrenia-related disorders in the relatives of

schizotypal probands and, conversely, an increased risk for schizotypal personality disorder in the relatives of schizophenia probands. At least some forms of schizotypal personality disorder involve biological abnormalities characteristic of schizophrenia. That is why in ICD-10, it is classified with schizophrenia rather than with personality disorders.[16]

(4) Treatment

A supportive relationship that counters cognitive distortions and ego-boundary problems may be useful. The therapist can involve an educational approach that fosters the development of social situations, or encourage risk-taking-behaviour in social situations. There is evidence to support the usefulness of low-dose antipsychotic medications in the treatment of schizotypal personality disorder.

SECTION - II

8. Cluster B Personality Disorder

1) Antisocial Personality Disorder

(DSM-IV Code: 301.7 & ICD-10 Code: F60.2)

The term 'moral insanity' was used by Pritchard (1835) to describe people with a pattern of repeated immoral behaviours for which they were not fully responsible. Many other psychiatrists too described this type of behaviour under different labels. Even though psychiatry has decried the use of this diagnosis for excusing antisocial acts, it has been steadfast in recognizing that such persons have significant psychological impairment. By the late nineteenth century, the term 'psychopathic personality' had become a broadly applicable category for persons with socially undesirable character traits. Harvey Cleckley's (1964) definition of the psychopath definitely influenced the DSM-I and DSM-II definitions of antisocial personality, whereas DSM-III and DSM-III-R were influenced by the empirical work of L.N. Robins (1966). L.N. Robin's definition consisted of an established pattern of conduct disorder in childhood, as well as a set of socially noxious behaviours (e.g., arrests, truancy, and assaultiveness) occurring in adulthood. This definition had the assets of being explicitly behavioural and of permitting reliable assessment but had the liabilities of being

cumbersome and too specific. Finally in DSM-IV, the Robins' behaviourally based version is combined with Cleckley's personologic traits to bring the disorder's definition back in line with clinical observations and with personality trait-based descriptions.

(1) Diagnostic Criteria

Diagnostic Criteria for Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following;
   (1) failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
   (2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
   (3) impulsivity or failure to plan ahead
   (4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
   (5) reckless disregard for safety of self or others
   (6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
   (7) lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years.

C. There is evidence of Conduct Disorder (refer the appropriate pages) with onset before age 15 years.

D. The occurrence of antisocial behaviour is not exclusively during the course of Schizophrenia or a Manic Episode.

Persons with antisocial personality disorder frequently lack empathy and tend to be callous, cynical, and contemptuous of the feelings, rights, and sufferings of others. They may have an inflated and arrogant self-appraisal and may be excessively opinionated, self-assured, or cocky. They may display a glib, superficial charm and can be quite voluble and verbally facile. They may be

irresponsible and exploitative in their sexual relationships. They may also be irresponsible as parents.

They may also experience dysphoria, including complaints of tension, inability to tolerate boredom, and depressed mood. They have associated Anxiety Disorders, Depressive Disorders, Substance-Related Disorders, Somatization Disorder, Pathological Gambling, and other disorders of impulse control. They often have features that meet criteria of the Borderline, Histrionic, and Narcissistic Personality Disorders.

Antisocial personality disorder appears to be associated with low socioeconomic status and urban settings. One should keep in mind that in urban settings antisocial behaviour may be part of a protective survival strategy. Besides, this trait cannot be diagnosed before age 18 years. It is much more common in males than in females.

The prevalence of this behaviour is about 3% in males and about 1% in females. It is more common among the first-degree biological relatives of those with the disorder than among the general population. The risk to biological relatives of females with the disorder tends to be higher than the risk to biological relatives of males. Adoption studies have indicated that both genetic and environmental factors contribute to the risk of this group of disorders.[17]

(2) Differential Diagnosis[18]

In Common with	Characteristics Shared	Exclusively characteristic of Antisocial Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Narcissistic Personality Disorder	Tough-minded, glib, superficial, exploitative, and unempathic	Narcissistic – does not have impulsivity, aggressions, and deceit; Antisocial – may not be as needy of the admiration and envy of others as the narcissistic.
Histrionic Personality Disorder	Impulsive, superficial, excitement seeking, reckless, seductive, and manipulative	Histrionic – tend to be more exaggerated in their emotions and do not characteristically engage in antisocial behaviours.

Paranoid Personality Disorder	Antisocial behaviour	Antisocial – motive is a desire for personal gain or to exploit others; Paranoid – motive is a desire for revenge
Borderline Personality Disorder	Emotional instability, aggressiveness	Antisocial – is less emotionally unstable and more aggressive

An individual with Substance-Related Disorder may not be diagnosed as antisocial unless signs of antisocial personality disorders were present in childhood and continued into adulthood. It cannot also be diagnosed if it is found only during the course of Schizophrenia or a Manic Episode. It should not be confused with criminal behaviour undertaken for gain that is not accompanied by the characteristic of this disorder. Only when antisocial personality traits are inflexible, maladaptive, and persistent and cause significant functional impairment or subjective distress do they constitute antisocial personality disorder.

(3) Aetiology

Studies done on twins and adoption indicate that genetic factors predispose to the development of antisocial personality disorder. There is evidence that impulsive and aggressive behaviours may be mediated by abnormal serotonin transporter functioning in the brain. Even in the absence of genetic vulnerability, the early family life of these persons has often had severe environmental handicaps in the form of absent, assaultive, or inconsistent parenting.[19]

(4) Treatment

This disorder cannot be successfully treated by the usual psychiatric interventions. In confined settings, such as the military or prisons, confrontation by peers may bring about changes in the antisocial behaviours. With the passing of years, the prevalence of these behaviours tends to decrease as these individuals become more aware of the social and interpersonal maladaptiveness of their noxious social behaviours.[20]

2) Borderline Personality Disorder

(DSM-IV Code: 301.83 & ICD-10 Code: F60.31)

The borderline personality disorder construct originated from the observations made by psychoanalytic psychotherapists who

were impressed by these patients' search for nurturance, their disregard for the usual boundaries of therapy, and their tendency to regress in unstructured situations. Various attempts were made to define it better which raised the question of whether such patients had an atypical form of mood disorder rather than an atypical form of schizophrenia as had been previously thought when it was included in DSM-III. Further empirical research led to the revisions of this disorder's construct. It is the most widely studied personality disorder. It is also common, occurring in approximately 2%-3% of the population and in every culture.

(1) Diagnostic Criteria

Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) frantic efforts to avoid real or imagined abandonment

(2) a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation

(3) identity disturbance: markedly and persistently unstable self-image or sense of self

(4) impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating)

(5) recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour

(6) affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

(7) chronic feeling of emptiness

(8) inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)

(9) transient, stress-related paranoid ideation or severe dissociative symptoms

Persons with borderline personality disorder may have a pattern of undermining themselves at the very moment a goal is about

to be realized like dropping out of school just before graduation. Some of them may develop psychotic-like symptoms (e.g., hallucinations, body-image distortions, ideas of reference, and hypnagogic phenomena) during times of stress. They may feel more secure with transitional objects like pets or inanimate possessions than with interpersonal relationships. Recurrent job losses, interrupted education, and broken marriages are common. Physical, verbal, and sexual abuse, neglect, hostile conflict, and early parental loss or separation are more common in the childhood histories of these persons.

The prevalence of this disorder is estimated to be about 2% to 3% of the general population. It is diagnosed predominantly (about 75%) in females.[21]

(2) Differential Diagnosis[22]

In Common with	Characteristics Shared	Exclusively characteristic of Borderline Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Histrionic Personality Disorder	Attention seeking, manipulative behaviour; and rapidly shifting emotions	Borderline – distinguished by self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and loneliness.
Schizotypal Personality Disorder	Paranoid ideas or illusions	Borderline – the symptoms are transient, interpersonally reactive, and responsive to external structuring
Paranoid Personality Disorder and Narcissistic Personality Disorder	Angry reaction to minor stimuli	Paranoid and narcissistic – have relative stability of self-image as well as the relative lack of self-destructiveness, impulsivity, and abandonment concerns
Antisocial Personality Disorder	Manipulative behaviour	Borderline – motive is to gain the concern of caretakers; Antisocial – motive is to gain profit, power, or some other material gratification
Dependent Personality Disorder	Fear of abandonment	Borderline - reactss to abandonment with feelings of emotional emptiness, rage, and demands; Dependent – reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support.

(3) Aetiology

The theories of psychoanalytic school have emphasized the importance of early parent-child relationships in the aetiology. These theories attribute this disorder to maternal mismanagement of the 2- to 3-year-old child's efforts to become autonomous, exaggerated maternal frustration that aggravates the child's anger, and inattention to the child's emotions and attitudes. It is also due to a high frequency of traumatic early abandonment, physical abuse, and sexual abuse. Usually these traumatic experiences occur within a context of sustained neglect from which the pre-borderline child develops an enduring rage and self-hatred. The lack of stably involved attachment during development is a source of the inability of borderline persons to maintain a stable sense of themselves or of others without ongoing contact.[23]

(4) Treatment

Therapists find extreme difficulties in dealing with such patients since they crave for the nurturing qualities. Also, they accuse with rage to the therapist's perceived failures. Often, therapists develop an intense negative countertransference and reject them. Intensive exploratory psychotherapies directed at modifying their basic character structure leading to experiencing of developing a stable, trusting relationship with the therapist, are facilitative. Supportive psychotherapies or group therapies also may bring about a significant change. Cognitive-behaviour interventions do have salutary effect on them. Medications may diminish specific problems such as impulsivity, affective lability, or intermittent cognitive and perceptual disturbances as well as irritability and aggressive behaviour.[24]

3) Histrionic Personality Disorder

(DSM-IV Code: 301.50 & ICD-10 Code: F60.4)

The forerunner of histrionic personality disorder can be found in the description of hysteria by Pierre Janet and Sigmund Freud. Janet focused on the role of actual seduction (or other trauma) in childhood. Freud focused on the unconscious elaboration of the child's sexual drive (i.e., libido). Later psychoanalysts observed that hysterical symptoms were often associated with a particular set of character traits and this led to the inclusion of the title hysterical type of personality disorder in DSM-II. Since the definition 'hysterical' was too broad, in DSM-III the label 'hysterical' was changed to the label 'histrionic'; this reflected the features of emotional instability and attention seeking. The modifications of DSM-III-R and DSM-IV helped distinguish this category from others and placed it within the range of less severe personality disorders that can be conceptualised as maladaptive variants of normally occurring traits. According to Chodoff (1982), this disorder represents a caricature of stereotypic feminity.

(1) Diagnostic Criteria

Diagnostic Criteria for Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) is uncomfortable in situations in which he or she is not the centre of attention
(2) interaction with others is often characterized by inappropriate sexually seductive or provocative behaviour
(3) displays rapidly shifting and shallow expression of emotions
(4) consistently uses physical appearance to draw attention to self
(5) has a style of speech that is excessively impressionistic and lacking in detail
(6) shows self-dramatization, theatricality, and exaggerated expression of emotion
(7) is suggestible, i.e., easily influenced by others or circumstances
(8) considers relationships to be more intimate than they actually are

Persons of histrionic personality disorder may have difficulty achieving emotional intimacy in romantic or sexual relationships. They may strive to control their partner through emotional manipulation or seductiveness and display a marked dependency on them. They may alienate friends with demands for constant attention and may become depressed when they are not the centre of attention. They seek novelty, stimulation, and excitement and have a tendency to become bored with their usual routine. They may also become intolerant of, or frustrated by, situations that involve delayed gratification and they need immediate satisfaction. It is associated with somatization disorder, conversion disorder, and major depressive disorder. Borderline, narcissistic, antisocial, and dependent personality disorders often co-occur. In the general population, the prevalence of this type of disorder is 2%-3%.[25]

(2) Differential Diagnosis[26]

In Common with	Characteristics Shared	Exclusively characteristic of Histrionic Personality Disorder or of the disorder with which it is compared or the difference between the two disorders.
Borderline Personality Disorder	Attention seeking, manipulative behaviour, and rapidly shifting emotions	Borderline personality disorder has self-destructiveness, angry disruptions in close relationships, and chronic feelings of deep emptiness and identity disturbance.
Antisocial Personality Disorder	Impulsive, superficial, excitement seeking, reckless, seductive, and manipulative	More exaggerated in their emotions and do not characteristically engage in antisocial behaviours. Manipulative behaviour - not to gain profit, power, or some other material gratification like antisocial but to gain nurturance.
Narcissistic Personality Disorder	Attention seeking	Not for their superiority and status like the narcissistic but as fragile or dependent.
Dependent Personality Disorder	Dependence on others	Dependent – dependence for praise and guidance Histrionic - dependence with flamboyant, exaggerated, emotional features.

(3) Aetiology

Psychoanalytic theory is of the opinion that histrionic personality disorder originates from the Oedipal phase of development (i.e., 3-5 years of age) when an overly eroticised relationship with the opposite-sex parent is unduly encouraged and the child fears that the consequences of this excitement will be the loss of, or retaliation by, the same-sex parent. However recent studies suggest that qualities such as emotional expressiveness and attention seeking may be characteristics of biogenetically determined temperament. Seen from this perspective, histrionic personality disorder is an extreme variant of a temperamental disposition, the environmental contributions for which may be less specific.[27]

(4) Treatment

Individuals with histrionic personality disorder are treated with individual psychodynamic psychotherapy. This treatment is directed to increasing the individuals' awareness of how their self-esteem is maladaptively tied to their ability to attract attention at the expense of developing other skills and how their shallow relationships and emotional experience reflect unconscious fears of real commitments. This awareness is raised through analysis of the here-and-now patient-therapist relationship rather than through the reconstruction of the childhood experiences.[28]

4) Narcissistic Personality Disorder

(DSM-IV Code: 301.81 & ICD-10 Code: F60.8)

It was Havelock Ellis (1898) who introduced the term 'narcissism' to describe a type of sexual perversion involving treating oneself as a sexual object. Later Freud adopted the term to describe a more general attitude of self-absorption and self-love. Then, analysts defined it as excessive self-love and grandiosity that develop in response to injured self-esteem. It was only during the 1980s the concept of narcissistic type personality disorder developed by the attention given to pathological narcissism in the psychoanalytic circles. Actually this attention was largely an outgrowth of Heinz Kohut's (1971,1977) theoretical and clinical contributions, many of which focused on nonpathological narcissism.

(1) Diagnostic Criteria

Diagnostic Criteria for Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

(3) believes that he or she is 'special' and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

(4) requires excessive admiration

(5) has a sense of entitlement, i.e., unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations

(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends

(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

(8) is often envious of others or believes that others are envious of him or her

(9) shows arrogant, haughty behaviours or attitudes

Because of the vulnerability in self-esteem, individuals with narcissistic personality disorder are very sensitive to 'injury' from criticism or defeat. Criticism may haunt them and leave them feeling humiliated, degraded, hollow, and empty even though they may not show it outwardly. They may react with disdain, rage, or defiant counterattack. It is possible that sustained feelings of shame or humiliation and the attendant self-criticism may be associated with social withdrawal, depressed mood, and Dysthymic or Major Depressive Disorder. Likewise sustained periods of grandiosity

may be associated with a hypomanic mood. This disorder is also associated with anorexia nervosa and substance related disorders. Histrionic, borderline, antisocial and paranoid personality disorders may be associated with this type of disorder. The prevalence of this disorder is less than 1% in the general population; it ranges from 2% to 16% in the clinical population. It is interesting to note that of those diagnosed with narcissistic personality disorder, 50%-70% are male.[29]

(2) Differential Diagnosis[30]

There is likelihood of other personality disorders being confused with narcissistic personality disorder because of the common features. Therefore it is necessary to distinguish among these disorders based on differences in their characteristic features. One may also meet individuals whose characteristics besides meeting the criteria of narcissistic personality disorder, may also meet the criteria of one or more disorders. In such cases all of them are to be diagnosed.

In Common with	Characteristics Shared	Exclusively characteristic of Narcissistic Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Histrionic, Antisocial and Borderline	Interactive styles are respectively coquettish, callous, and needy	Grandiosity is typical of narcissistic personality disorder.
Borderline and Histrionic	Require much attention	Narcissistic - Needs that attention as admiring.
Obsessive-Compulsive Personality Disorder	Profess a commitment to perfectionism and believe that others cannot do things as well	The feeling that accompanies the profession and belief in obsessive-compulsive is self-criticism, and in narcissistic the feeling of having achieved perfection.
Schizotypal and Paranoid Personality Disorders	May share suspiciousness and social withdrawal	Narcissistic have them from fears of having their imperfections or flaws revealed.

(3) Aetiology

There is little scientific evidence about the pathogenesis of narcissistic personality disorder. According to the psychoanalytic view, this disorder develops in persons who have had their fears, failures, or dependency responded to with criticism, disdain, or neglect during their childhood years. Such experiences leave them contemptuous of such reactions in themselves and others. They develop a veneer of invulnerability and self-sufficiency that masks their underlying emptiness and constricts their capacity to feel deeply.[31]

(4) Treatment

Individual psychodynamic psychotherapy, including psychoanalysis, is mostly used as treatment. In accordance with the theory of Kohut, some therapists believe that the vulnerability to narcissistic injury indicates that intervention should be directed at conveying empathy for the patient's sensitivities and disappointments. In this approach, a positive idealized transference is allowed to develop which will later be disillusioned by the inevitable frustrations encountered in therapy. And that will clarify the excessive nature of the patient's reactions to frustrations and disappointments. According to Kernberg (1974, 1975) the vulnerability should be addressed earlier and more directly by interpretations and confrontations by which these persons will come to recognize their grandiosity and its maladaptive consequences.[32]

SECTION - III

9. Cluster C Personality Disorder

1) Avoidant Personality Disorder

(DSM-IV Code: 301.82 & ICD-10 Code: F60.6)

Avoidant personality disorder was a new addition to DSM-III, theoretically derived from Millon's (1981) typology of personality disorders corresponding to his active-detached pattern. This disorder has some historical clinical antecedents like Kretschmer's (1925) hyperaesthetic type, Schneider's (1959) sensitive type, Horney's (1945) detached type, and Fenichel's (1945) phobic character. This disorder construct was brought closer to the psychoanalytic construct of the phobic character.

(1) Diagnostic Criteria

Diagnostic Criteria for Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
(2) is unwilling to get involved with people unless certain of being liked
(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) is preoccupied with being criticized or rejected in social situations
(5) is inhibited in new interpersonal situations because of feelings of inadequacy.
(6) views self as socially inept, personally unappealing, or inferior to others
(7) is usually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Individuals with avoidant personality disorder often vigilantly appraise the movements and expressions of those with whom they come into contact. They are anxious about the possibility of reacting to criticism with blushing or crying. Their major problem

is with social and occupational functioning. They desire affection and acceptance and may fantasize about idealized relationships with others. This disorder tends to be diagnosed with Mood and Anxiety Disorders (especially Social Phobia of the Generalized Type), and with Dependent Personality Disorder, Borderline Personality Disorder, Paranoid Personality Disorder, Schizoid Personality Disorder and Schizotypal Personality Disorder. One needs to keep in mind that avoidant behaviour may be the result of problems in acculturation following immigration. Children and adolescents too appear to be avoidant which is developmentally appropriate. The prevalence of this disorder in the general population is between 0.5% and 1.0%. Usually the avoidant behaviour often starts in infancy or childhood with shyness, isolation, and fear of strangers and new situations. It is likely that in adults this disorder tends to become less evident or to remit with age.[33]

(2) Differential Diagnosis[34]

There seems to be a great deal of overlap between Avoidant Personality Disorder and Social Phobia, Generalized Type.

In Common with	Characteristics Shared	Exclusively characteristic of Avoidant Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Panic Disorder with Agoraphobia	Avoidance	In Panic Disorder the avoidance starts after the onset of panic but in Avoidant it tends to start early and is marked by a lack of clear precipitants, and has a stable course.
Dependent Personality Disorder	Feeling of inadequacy, hypersensitivity to criticism, and a need for reassurance	Motive for Avoidant is to avoid humiliation and rejection but in Dependent the motive is to be taken care of.
Schizoid Personality Disorder and Schizotypal Personality Disorder	Social isolation	Avoidant want to have relationships with others and feel their loneliness deeply; but Schizoid and Schizotypal may be content with and even prefer their social isolation.
Paranoid Personality Disorder	Reluctance to confide in others	Reluctance in Avoidant is due more to a fear of being embarrassed or being found inadequate; but in Paranoid due to a fear of others' malicious intent.

(3) Aetiology

Millon (1981) (whose work suggested the type avoidant personality disorder to DSM) says that the disorder develops from parental rejection and censure, which may be reinforced by rejecting peers. According to psychodynamic theory, the avoidant behaviour may derive from early life experiences that lead to an exaggerated desire for acceptance or an intolerance of criticism. Biological research has implicated the importance of inborn temperament in the development of avoidant behaviour. In his research, Kagan (1989) found that some children as young as 21 months of age manifest increased physiological arousal and avoidant traits in social situations (e.g., retreat from the unfamiliar and avoidance of interactions with strangers) and that this social inhibition tends to persist for many years.[35]

(4) Treatment

Since the patients are experiencing excessive fear of rejection and criticism and are reluctant to form relationships, it is difficult to engage them in treatment. Therapists could use supportive techniques, be sensitive to the patient's hypersensitivity, and employ gentle interpretation of the defensive use of avoidance. Slowly depending upon their willingness, other forms of therapies could be used, including short-term, long-term, and psychoanalytic approaches. Therapists' countertransference reactions such as overprotectiveness, hesitancy to adequately challenge the patient, or excessive expectations for change may sabotage the chance of change in the patients. Assertiveness and social skills training are likely to increase patients' confidence and willingness to take risks in social situations. Using cognitive techniques, gentle challenges of the pathological assumptions about their sense of ineptness may also be useful. Homogeneous supportive groups may help them develop social skills. The patients may improve with treatment with monoamine oxidase inhibitors or serotonin reuptake inhibitors. Anxiolytics at times may help patients better manage severe anxiety caused by facing the previously avoided situations or while trying new behaviours.[36]

2) Dependent Personality Disorder

(DSM-IV Code: 301.6 & ICD-10 Code: F60.7)

The forerunner of the dependent personality disorder is Abraham's (1927) 'oral' character. This disorder was thought to result from fixation at the first, or oral, stage of psychosexual development. This disorder was similar to Horney's 'compliant' type. Dependent personality disorder was a subtype of passive-aggressive personality disorder in DSM-I and did not become a separate disorder until DSM-III. Finally, it was DSM-IV that put greater emphasis on the disorder's central features and attempted to diminish its overlap with other personality disorders.

(1) Diagnostic Criteria

Diagnostic Criteria for Dependent Personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others

(2) needs others to assume responsibility for most major areas of his or her life

(3) has difficulty expressing disagreement with others because of fear of loss of support or approval. Note: Do not include realistic fears of retribution.

(4) has difficulty initiating projects or doing things on his or her own (because of a lack of self-confidence in judgement or abilities rather than a lack of motivation or energy)

(5) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant

(6) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself

(7) urgently seeks another relationship as a source of care and support when a close relationship ends

(8) is unrealistically preoccupied with fears of being left to take care of himself or herself

Pessimism and self-doubt often characterize individuals with dependent personality disorder. They tend to belittle their abilities and assets, and may constantly refer to themselves as 'stupid.' Criticism and disapproval become proofs of their worthlessness and they lose faith in themselves. They tend to seek overprotection and dominance from others. They may avoid positions of responsibility and become anxious when faced with decisions. They may be in an increased risk of Mood Disorders, Anxiety Disorders, and Adjustment Disorder. This disorder often co-occurs with Borderline, Avoidant and Histrionic Personality Disorders. Chronic physical illness or Separation Anxiety Disorder in childhood or adolescence may predispose the individual to the development of this disorder.[37]

(2) Differential Diagnosis[38]

In Common with	Characteristics Shared	Exclusively characteristic of Dependent Personality Disorder or of the disorder with which it is compared or the difference between the two disorders.
Boderline Personality Disorder	Fear of abandonment	Borderline reacts to abandonment with feelings of emotional emptiness, rage, and demands; Dependent reacts with increasing appeasement and submissiveness and urgently seeks a replacement relationship to provide caregiving and support.
Histrionic Personality Disorder	Strong need for reassurance and approval and may appear childlike and clinging.	Dependent - self-effacing and docile behaviour; Histrionic - gregarious flamboyance with active demands for attention.
Avoidant Personality Disorder	Feelings of inadequacy, hypersensitivity to criticism, and a need for reassurance	Dependent - have a pattern of seeking and maintaining connetions to important others, rather than avoiding and withdrawing from relationships; Avoidant - have such a strong fear of humiliation and rejection that they withdraw until they are certain they will be accepted.

(3) Aetiology

Abraham suggests that the dependent character derives from either overindulgence or underindulgence during the oral phase of development (i.e., birth to age 2). Later studies gave more weight to the underindulgence hypothesis. But studies of adults have not supported a specific association between feeding or other oral habits in childhood and dependency in adulthood. Genetic or constitutional factors, such as innate submissiveness, may have a role to play in its origin. Cultural and social factors may also be involved in its aetiology. In some cultures, dependency is considered as normative and desirable.[39]

(4) Treatment

Usually the patients enter therapy with complaints of depression or anxiety that may be precipitated by the threatened or actual loss of a dependent relationship. They are known to respond well to various types of individual psychotherapy. Treatment may be particularly helpful if it explores patients' fears of independence; uses the transference to explore their dependency; and is directed towards increasing patients' self-esteem, sense of effectiveness, assertiveness, and independent functioning. Group therapy and cognitive-behaviour therapy aimed at increasing independent functioning, plus assertiveness and social skills training are found useful for some patients. If their dependence is found in relationship, then couples or family therapy may be helpful.[40]

3) Obsessive-Compulsive Personality Disorder

(DSM-IV Code: 301.4 & ICD-10 Code: F60.5)

Freud (1908/1924) observed in the early 1900s, that persons with obsessive-compulsive personality disorder were characterized by the three peculiarities of 1. orderliness (which included cleanliness and consciousness), 2. parsimoniousness, and 3. obstinacy. These individuals are described by Ernest Jones (1918/1938) as being preoccupied with cleanliness, money, and time. This disorder is often being referred to as 'anal character.' This disorder is mentioned in every version of DSM. In European psychiatric literature, this disorder has been referred to as 'anancastic personality disorder,' a term used by Kretschmer and Schneider in the 1920s and still used in ICD-10.

(1) Diagnostic Criteria

Diagnostic Criteria for Obsessive-Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost

(2) shows perfectionism that interferes with task completion (e.g., is unable to complete a project because his or her own overly strict standards are not met)

(3) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

(4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

(5) is unable to discard worn-out or worthless objects even when they have no sentimental value

(6) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

(7) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes

(8) shows rigidity and stubbornness

People with obsessive-compulsive personality disorder may have such difficulty in deciding which tasks take priority or what is the best way of doing some particular task that they may never get started on anything. They are usually upset or angry in situations in which they are not able to maintain control of their physical or interpersonal environment. They may experience righteous indignation over a seemingly minor matter. They are particularly attentive to their relative status in dominance-submission relationships, and may display excessive deference to an authority they

respect, and excessive resistance to authority that they do not respect. Their emotional expressions are highly controlled or in a stilted fashion. They may be very uncomfortable in the presence of others who are emotionally expressive. Thus they carefully hold themselves back until they are sure that whatever they say will be perfect. As they are preoccupied with logic and intellect, they are intolerant of affective behaviour of others. They are known to have difficulty expressing tender feelings, rarely paying compliments. The prevalence of this disorder is about 1% in community samples.[41]

(2) Differential Diagnosis[42]

In Common with	Characteristics Shared	Exclusively characteristic of Obsessive-Compulsive Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Obsessive-Compulsive Disorder	Obsession and compulsion	Obsessive-compulsive disorder – is distinguished by the presence of true obsessions and compulsions
Narcissistic Personality Disorder	Profess a commitment to perfection and believe that others cannot do things as well	Obsessive-compulsive – are usually self-critical and thus doubt their achievement; Narcissistic – believe that they have achieved perfection.
Antisocial Personality Disorder	Lacking generosity	Obsessive-compulsive – adopts a miserly spending style toward both self and others; antisocial – will indulge themselves but miserly towards others.
Schizoid Personality Disorder	Apparent formality and social detachment	Obsessive-compulsive – the characteristics stem from discomfort with emotions and excessive devotion to work; Schizoid – they stem from a fundamental lack of capacity for intimacy.

(3) Aetiology

According to Freud, obsessive-compulsive personality disorder derives from difficulties occurring during the anal stage of psychosexual development (age 2-4 years). This view was echoed and elaborated on by subsequent psychoanalytic thinkers, such as Karl Abraham and Wilhelm Reich (1933). Children's infantile anal-erotic libidinal impulses conflict with parental attempts to socialize them, especially to toilet train them. These theories give importance to children's perception of parental disapproval during toilet training, and of ensuing parent-child control struggles which Rado (1959) referred as 'the battle of the chamber pot.' However, these factors are not currently considered central to the aetiology of this disorder. Perhaps, conflicts arising during toilet training such as those characteristic of Erikson's (1950) stage of autonomy versus shame and continuing during other developmental stages do play a role in this disorder's aetiology (Perry and Vaillant 1989). We can say as a general observation that excessive parental control, criticism, and shaming may result in an insecurity that is defended against with perfectionism, orderliness, and an attempt to maintain excessive control. Freud and Rado believed that constitutional factors may have a part to play in the formation of this disorder; this needs to be studied empirically.[43]

(4) Treatment

The therapists may find it difficult to treat them because of their excessive intellectualization and difficulty in expressing emotions. All the same these people seem to respond well to psychoanalytic psychotherapy or psychoanalysis. The therapists need to be active in therapy sessions and focus on the feelings and emotions which the patients avoid instead of intellectualising with the patients. Defences such as rationalization, isolation, undoing, and reaction formation need to be addressed and clarified. In the therapy there may be power struggles as a mark of the patient's excessive need for control. Sometimes cognitive techniques may also be used to diminish the patient's excessive need for control and perfection. Dynamically oriented group therapies that focus on feelings may provide insight and increase their comfort with exploring and expressing new affects. The patients usually tend to avoid group therapies because of their need to control. They are afraid that they will lose control of the group.[44]

SECTION - IV

10. Personality Disorder Not Otherwise Specified (NOS)

(DSM-IV Code: 301.9 & ICD-10 Code: F60.9)

Under 'Personality Disorder Not Otherwise Specified' are included disorders of personality functioning that do not meet criteria for any specific personality disorder. Take for example the presence of features of more than one specific personality disorder that do not meet the full criteria for any one personality disorder ('mixed personality'), but together cause clinically significant distress or impairment in one or more important areas of functioning (e.g., social or occupational). This category is also used when the clinician judges that a specific personality disorder that is not included in the classification is appropriate (e.g., depressive personality disorder and passive-aggressive personality disorder).

There are three personality disorders (depressive, negativistic and self-defeating personality disorders) that were considered for inclusion in DSM-IV on the basis of their historical tradition, clinical utility and/or empirical support. However, for various reasons it was thought that they require further study to merit special treatment like the other disorders that are instituted in DSM-IV. These three disorders involve chronically morose people who have problems with direct expression of their aggression.[45]

1) Depressive Personality Disorder

Depressive personality disorder may have, of all the personality disorders, the longest clinical tradition, having been recognized 2,000 years ago by Hippocrates in his description of the 'black gall,' or melancholic temperament. Kraepelin (1921) too described this temperament and considered it a depressive-spectrum disorder, a constitutional traitlike variant of the more severe depressive disorders and one predisposing to their occurrence. The description of this disorder by Schneider (1959) led to its inclusion in ICD-9 as an affective personality disorder. Kernberg (1988), who drew from the writings of Laughlin, emphasized its psychodynamic features, which include a severe superego, the inhibited expression of aggression, and an excessive dependence that is defended against with counterdependence. On account of the disorder's historical tradition, its inclusion in ICD-9, and some empirical evidence in its support, it was added to the appendix in DSM-IV.

(1) Diagnostic Criteria

Research Criteria for Depressive Personality Disorder

A. A pervasive pattern of depressive cognitions and behaviours beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) usual mood is dominated by dejection, gloominess, cheerlessness, joylessness, unhappiness

(2) self-concept centers around beliefs of inadequacy, worthlessness, and low self-esteem

(3) is critical, blaming, and derogatory toward self

(4) is brooding and given to worry

(5) is negativistic, critical, and judgmental toward others

(6) is pessimistic

(7) is prone to feeling guilty or remorseful

B. Does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

Individuals with depressive personality disorder may be quiet, introverted, passive, and unassertive, preferring to follow others rather than taking the lead. Occurrence of this pattern is noted with equal frequency in females and males. Individuals with this disorder may be predisposed to developing Dysthymic Disorder and possibly Major Depressive Disorder. These conditions may exist on a spectrum, with depressive personality disorder being the early-onset, persistent, traitlike variant of the depressive disorders. Depressive personality disorder may have an increased prevalence in family members of probands with Major Depressive Disorder. Conversely, Major Depressive Disorder may occur with increased frequency in family members of probands with depressive personality disorder who do not themselves have Major Depressive Disorder.[46]

(2) Differential Diagnosis

According to DSM-IV, individuals whose presentation meets these research criteria will be diagnosed as having personality disorder not otherwise specified. The relationship between this disorder with other personality disorders is not known, but substantial overlap may exist among them.[47]

(3) Treatment

Individuals with depressive personality disorder may respond to psychoanalysis or psychoanalytic psychotherapy because of their good reality testing, good ego identity, and use of relatively mature defence mechanisms. Antidepressant medication may have a good effect on them.[48]

2) Passive-Aggressive Personality Disorder

(Negativistic Personality Disorder)

Negativistic personality disorder entered the appendix in DSM-IV as a replacement for the excessively narrow category of passive-aggressive personality disorder, which was thought to represent a single defence mechanism rather than a personality disorder. There are other limitations of passive-aggressive personality disorder, which are its limited empirical support and the fact that passive-aggressive behaviour can be normative, even laudable, in certain situations. Negativistic personality disorder is a broader construct with historical precedents, including Schneider's (1923) 'ill-tempered depressives.' The clinical features of this disorder and its differentiation from other personality disorders remain to be empirically confirmed.

(1) Diagnostic Criteria

Research Criteria for Passive-Aggressive Personality Disorder

A. A pervasive pattern of negativistic attitudes and passive resistance to demands for adequate performance, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) passively resists fulfilling routine social and occupational tasks

(2) complains of being misunderstood and unappreciated by others

(3) is sullen and argumentative

(4) unreasonably criticizes and scorns authority

(5) expresses envy and resentment toward those apparently more fortunate

(6) voices exaggerated and persistent complaints of personal misfortune

(7) alternates between hostile defiance and contrition

B. does not occur exclusively during Major Depressive Episodes and is not better accounted for by Dysthymic Disorder.

Patients are often overtly ambivalent, wavering indecisively from one course of action to its opposite. A conflict that is intense between dependence on others and the desire for self-assertion is characteristic of the individuals. Evidently their self-confidence is often poor despite a superficial bravado. These individuals foresee the worst possible outcome for most situations, even those that are going well. This defeatist outlook can evoke hostile and negative responses from others who are subjected to the complaints of these individuals. This behavioural pattern often occurs in individuals with Borderline, Histrionic, Paranoid, Dependent, Antisocial, and Avoidant Personality Disorders. Of course, passive-aggressive behaviours are frequently encountered in everyday life, especially among those in authoritarian situation (e.g., work, military, prison) that do not tolerate other forms of assertiveness. But only when this pattern becomes inflexible, maladaptive, and causes significant functional impairment or subjective distress does it constitute a disorder.[49]

(2) Differential Diagnosis[50]

In Common with	Characteristics Shared	Exclusively characteristic of Negativistic Personality Disorder or of the disorder with which it is compared or the difference between the two disorders
Oppositional Defiant Disorder	Pattern of negativistic attitude and problems with authority figures	Negativistic – pattern is diagnosed in adults; Oppositional – pattern is diagnosed in children

(3) Treatment

Treatment of passive-aggressive personality disorder is very difficult. Since these individuals resent authority, even the counsellors will be mistrusted. Since they cannot openly come out with their criticism and demands for fear of reprisal, it is good to offer them a safe environment where they can express themselves without fear. I have noticed that those who are under formation usually adopt a passive-aggressive attitude on account of their inability to express their thoughts and feelings openly lest they are penalized.

3) Self-Defeating Personality Disorder

Self-defeating personality disorder has been the subject of much controversy in psychiatry. For sure, this type has a significant historical and clinical tradition, beginning with Kraft-Ebbing's nineteenth-century description of sexual masochism (which is classified as a paraphilia in DSM) and Freud's subsequent description of moral masochism, a pattern of nonsexual submissive behaviour that leads to psychological pain and mistreatment. All the same, there was considerable concern about the misuse of the diagnosis of this disorder, especially that it may be misapplied to women who are actually being abused and thereby be used to blame the victim. This concern also is one of the reasons why this type has never been an official psychiatric diagnosis. Though it was included in the DSM-III-R appendix, it is not included in DSM-IV.

(1) Diagnostic Criteria[51]

Research Criteria for Self-Defeating Personality Disorder

(1) A pervasive pattern of self-defeating behaviour that does not occur only in response to, or in anticipation of, physical, sexual, or psychological abuse.

(2) Feel unworthy of being treated well and, as a result, treat themselves poorly and unwittingly encourage others to make them suffer.

(3) They may for example, reject opportunities for pleasure, choose people or situations that lead to mistreatment or failure, and incite others to become angry with them or reject them.

(4) If things do go well for them, they attempt to undermine themselves by, for example, becoming depressed or causing themselves pain.

(2) Treatment

Treatment of this disorder is complicated because of the patient's self-defeating tendencies. They may unknowingly undermine the treatment and their progress because they feel undeserving of improvement or happiness.

Insight-oriented psychotherapy or psychoanalysis exploring the patient's need to be victimized and making their investment in suffering ego-dystonic may allow a successful outcome.

11. CONCLUSION

Since 1980, when personality disorders were put on a separate axis in DSM-III, clinical interest and research in these disorders have grown enormously. The subsequent period has brought to the fore specific treatment strategies and a better understanding of the prognosis and aetiology of these disorders. The challenges that face the research are an explication of the boundaries between personality disorders and normalcy and Axis I conditions and secondly the discovery of biogenetic bases for personality disorder classification. In all likelihood, with the continued inquiry by clinical and basic-science investigators, the classification system will continue to change so that it becomes even more tightly linked to the aetiology and treatment of these disorders.[52]

2

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS

1. Introduction

Under the title 'Schizophrenia and other psychotic disorders' we include schizophrenia and its subtypes, schizophreniform disorder, schizoaffective disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, psychotic disorder due to a general medical condition, substance-induced psychotic disorder, and psychotic disorder not otherwise specified (NOS).

The disorders having psychotic symptoms as the defining feature are included under the title 'Schizophrenia and Other Psychotic Disorders.' Other disorders that may be with psychotic symptoms (but not as defining features) are included in other sections: as Dementia of the Alzheimer's Type and Substance-Induced Delirium are under the title 'Delirium, Dementia, and Amnestic and Other Cognitive Disorders.' Major Depressive Disorder, With Psychotic Features is found under the title 'Mood Disorders.'

Now what do we mean by the word 'psychotic?' The term 'psychotic' has undergone a number of different definitions and none of them have received universal acceptance. The narrowest definition is restricted to delusions and prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature. A less restrictive definition will also include prominent hallucinations that the individual does realize as hallucinatory experiences. A very broad definition includes other positive symptoms of Schizophrenia (i.e., disorganized speech, grossly disorganized or catatonic behaviour). Of course these definitions are based on symptoms. The definition used in DSM-II and ICD-9 was probably far too inclusive, and focused on the severity of functional impairment: a mental disorder was termed 'psychotic' if it resulted in 'impairment that grossly interferes with

the capacity to meet ordinary demands of life.' At last, the term has been defined conceptually as a loss of ego boundaries or a gross impairment in reality testing. In this chapter, the different aspects of the various definitions of psychotic are used. For example, in the sections of Schizopherenia, Schizophreniform Disorder, Schizoaffective Disorder, and Brief Psychotic Disorder, the term 'psychotic' refers to delusions, any prominent hallucinations, disorganized speech, or disorganized or catatonic behaviour. In the sections of Psychotic Disorder Due to a General Medical Condition and in Substance-induced Psychotic Disorder, 'psychotic' refers to delusions or only those hallucinations that are not accompanied by insight. In Delusional Disorder and Shared Psychotic Disorder, 'psychotic' is equivalent to delusional.[1]

2. Schizophrenia

(DSM-IV Code: 295xx & ICD-10 Code: F20.xx)

Schizophrenia is one of the most tragic and devastating diseases in psychiatry. Its onset is very early at a young age and so the patients usually live many years after the onset of the disease and continue to suffer its effects, which prevent them from leading fully normal lives like attending school, working, having a close network of friends, marrying, or having children. It also creates a huge economic burden for society and costs enormous social and psychological anguish to patients and their families.

In the 1980s, a reassessment was done on schizophrenia. Due to the introduction of the neuroleptic medicine, there was a wave of optimism about the disease. There was a movement of deinstitutionalization of the patients, and the patients were sent home. Slowly it was realized that neuroleptics had only a limited ability to control the symptoms of schizophrenia; there are also health risks with long-term exposure to the drugs. Therefore during the early 1990s, regrouping and reassessment of the disease led to a more realistic, integrated, and multifaceted approach to understanding this complex disorder. Thus in the late 1990s, a new era of guarded optimism emerged. It was understood that the best treatment approaches combine medication with various forms of psychosocial care; attempts are made to integrate genetics, neurochemistry, and neuropathology. The rapidly evolving techniques in brain imaging and histopathology have provided a major breakthrough in understanding schizophrenia.[2]

1) Historical Overview

Schizophrenia and related disorders have been recognized in almost all the cultures. Technical descriptions appear in books such as Reginald Scot's 'Discoveries of Witchcraft' in the 16th century and the classic psychiatric writings of Pinel in the 18th century. It was Emil Kraepelin (1856-1926) who is credited with delineating schizophrenia, principally on the basis of course and outcome. He observed that some of the mental patients whom he treated in Dorpat, Heidelberg and Munich, began to have symptoms such as delusions and emotional withdrawal at a relatively early age and that these patients were likely to have a chronic and deteriorating course. Kraepelin worked with his colleague Alzheimer, who studied patients with serious cognitive impairment and deterioration beginning at a later age and this condition is now referred to as 'Alzheimer's disease.' It was evident that some patients had deterioration starting at an early age and others had it at a later age. Therefore Kraepelin chose to distinguish the patients with deterioration at an early age from those at a late age by the term 'dementia praecox.' He also distinguished dementia praecox from 'manic-depressive illness' which has the age at onset distributed throughout life and a more episodic and less deteriorating course and outcome.

At the insistence of Eugen Bleuler (1857-1939), 'dementia praecox' was eventually renamed 'schizophrenia.' He insisted that the fundamental and unifying abnormality in schizophrenia was cognitive impairment, which he conceptualised as 'splitting' or 'loosening' in the 'fabric of thought.' Since 'thought disorder' was the essential and pathognomonic symptom of schizophrenia, he named the illness after this symptom: 'schizophrenia,' or the fragmenting of mental capacities. He also noticed that affective blunting, peculiar and distorted thinking (autism), avolition, impaired attention, and conceptual indecisiveness (ambivalence) were nearly equally important; he referred to this group of symptoms as 'fundamental,' whereas other symptoms such as delusions and hallucinations were regarded as 'accessory,' since they could occur in other disorders such as manic-depressive illness. He also noticed that some patients have a full recovery, some others have a relatively chronic course but do not deteriorate, and some patients begin to experience symptoms of schizophrenia in their 20s, 30s, or 40s. For the above reasons the term 'schizophrenia' was preferred to 'dementia praecox.' For several generations the Bleulerian

formula of 'Four A" - associations, affect, autism, and ambivalence was taught. Thought disorder (associative loosening or incoherence) was considered the most important among these.

Kraepelin's definition was of course concise but narrow. According to him, dementia praecox was an illness with a characteristic age at onset in the teens or early twenties that had a relatively poor outcome and led much of the time to relatively severe cognitive and emotional impairment. Though he emphasized the importance of cognitive impairment (i.e., dementia), he did not choose any single symptom as characteristic or pathognomonic. His description of the clinical phenomenology stresses a mixture of delusions, hallucinations, motor signs and symptoms, emotional blunting, avolition, and social isolation.

The German psychiatrist Kurt Schneider (1887-1967) introduced his concept of 'first-rank symptoms' to the English-speaking world. He introduced a set of cross-sectional symptoms, specific delusions and hallucinations that were different from the Bleulerian symptoms.

2) Kurt Schneider's First-Rank symptoms[3]

Kurt Schneider's First-Rank symptoms
1. Hallucination of one's thoughts being spoken aloud
2. Hallucination of voices in the form of a running commentary about the patient
3. Hallucination of voices conversing about the patient ('third person' hallucination) or arguing
4. Somatic hallucination attributed to outside forces (e.g., X rays, hypnosis)
5. Delusions of thoughts being withdrawn or inserted from patient's mind by an outside person or force
6. Delusion of thoughts being broadcast so that patient's private thoughts are known to others
7. Delusional perceptions in which highly personal meanings are attributed to perceptions
8. Delusions of being influenced or forced to do things or want things the patient does not wish to do and does not want
9. Delusions of being made to feel emotions or sensations (often sexual) that are not the patient's own

The above developments led to a reassessment of schizophrenia and other mental disorders in DSM-III. With the research and advancement in psychiatry, DSM-IV is of the opinion that deficit symptoms can be reliably defined and should be considered as core features of the disorder.[4]

3) Difference among DSM-III, DSM-III-R, and DSM-IV[5]

Difference among DSM-III, DSM-III-R, and DSM-IV Criteria for Schizophrenia

DSM-III	DSM-III-R	DSM-IV
Characteristic active-phase symptoms	**Characteristic active-phase symptoms for 1 week or more**	**Characteristic active-phase symptoms 1 month or more (less if treated)**
1. Deterioration in functioning	1. Impairment in functioning	1. Social/occupational dysfunction
2. Duration: at least 6 months or more (including active phase)	2. Duration: at least 6 months or more (including active phase)	2.Duration: at least 6 months or more (including active phase)
3. Depression and mania ruled out	3. Schizoaffective disorder and psychotic mood disorder ruled out	3. Schizoaffective disorder and psychotic mood disorder ruled out
4. Organic mental disorder and mental retardation ruled out	4. Organic mental disorder ruled out	4. Effects of substance or general medical condition ruled out
5. Onset before age 45	5. Autistic disorder ruled out	5. If there is a history of pervasive developmental disorder, prominent delusions, hallucinations must also be present for at least 1 month (or less if successfully treated)

Classification of Course	Classification of Course	Classification of Course
Subchronic (> 6 months but < 2 yrs)	Subchronic (> 6 months but < 2 yrs)	1. Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); also specify if: With Prominent Negative Symptoms
Chronic (> 2 yrs)	Chronic (> 2 yrs)	2. Episodic With No Interepisode Residual Symptoms
Subchronic with acute exacerbation	Subchronic with acute exacerbation	3. Continuous (prominent psychotic symptoms are present throughout the period of observation); also specify if: With Prominent Negative Symptoms
Chronic with acute exacerbation	Chronic with acute exacerbation	4. Single Episode In Partial Remission; also specify if: With Prominent Negative Symptoms
In remission	In remission	5. Single Episode In Full Remission
	Unspecified	6. Other or unspecified pattern

4) Diagnostic Criteria[6]

Diagnostic Criteria for Schizophrenia

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated):

(1) delusions

(2) hallucinations

(3) disorganized speech (e.g., frequent derailment or incoherence)

(4) grossly disorganized or catatonic behaviour

(5) negative symptoms, i.e., affective flattening, alogia (poverty of speech), or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other.

B. Social/occupation dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal (an early or premonitory sign or symptom of a disorder) or residual (the phase of an illness that occurs after remission of the florid symptoms or the full syndrome) symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder With Psychotic Features have been ruled out because either (1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosis of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

Classification of longitudinal course (can be applied only after at least 1 year has elapsed since the initial onset of active-phase symptoms):

1. Episodic With Interepisode Residual Symptoms (episodes are defined by the reemergence of prominent psychotic symptoms); also specify if: With Prominent Negative Symptoms

2. Episodic With No Interepisode Residual Symptoms

3. Continuous (prominent psychotic symptoms are present throughout the period of observation); also specify if: With Prominent Negative Symptoms
4. Single Episode In Partial Remission; also specify if: With Prominent Negative Symptoms
5. Single Episode In Full Remission
6. Other or Unspecified Pattern.

Clinical manifestations of schizophrenia and schizophreniform disorders are diverse and can change over time. Many symptoms are obvious, such as hallucinations, and others such as affective blunting or incongruity are relatively subtle and can be easily missed. Therefore a variety of methods have been developed to describe and classify the multiplicity of symptoms in schizophrenia. Traditional understanding of schizophrenia as a type of 'psychosis' has been elusive. Formerly subjective and internal psychological experience were stressed and psychosis was defined as an 'impairment in reality testing.' Of late, psychosis has been defined objectively and operationally as the occurrence of hallucinations and delusions. Since schizophrenia is characterized by so many different types of symptoms, clinicians have tried to simplify the description of the clinical presentation by dividing the symptoms into subgroups. The most widely used subdivision classifies the symptoms as positive and negative.

5) Characteristic Symptoms

The essential features of schizophrenia are a mixture of characteristic signs and symptoms (both positive and negative) that have been present for a significant portion of time during a 1-month period (or for a shorter time if successfully treated), with some signs of the disorder persisting for at least 6 months (Criteria A and C). The characteristic symptoms of schizophrenia involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioural monitoring, affect, fluency and productivity of thought and speech, hedonic capacity, volition and drive, and attention. No single symptom is pathognomonic of schizophrenia. The diagnosis involves the recognition of a constellation of signs and

symptoms associated with impaired occupational or social functioning.[7]

6) Positive and Negative Symptoms

Characteristic symptoms (Criterion A) may be understood as falling into two broad categories – positive and negative. The positive symptoms appear to reflect an excess or distortion of normal functions, whereas the negative symptoms appear to reflect a diminution or loss of normal functions. The positive symptoms (Criteria A1-A4) include distortions or exaggerations of inferential thinking (delusion), perception (hallucination), language and communication (disorganized speech), and behavioural monitoring (grossly disorganized or catatonic behaviour). These positive symptoms may comprise two distinct dimensions, which may in turn be related to different underlying neural mechanisms and clinical correlations: the 'psychotic dimension' which includes delusions and hallucinations, whereas the 'disorganization dimension' which includes disorganized speech and behaviour. Negative symptoms (Criterion A5) include restrictions in the range and intensity of emotional expression (affective flattening), in the fluency and productivity of thought and speech (alogia), and in the initiation of goal-directed behaviour (avolition).[8]

Symptoms in Schizophrenic Patients[9]

Positive Symptom	Negative Symptom
Hallucinations:	**Affective Flattening**:
Auditory	Unchanging facial expression
Voices commenting	Decreased spontaneous movements
Voices conversing	Paucity of expressive gestures
Somatic-tactile	Poor eye contact
Olfactory	Affective nonresponsivity
Visual	Inappropriate affect
	Lack of vocal inflections
Delusions:	
Persecutory	**Alogia**:
Jealous	Poverty of speech
Guilt, sin	Poverty of content of speech
Grandiose	Blocking

Religious	Increased response latency
Somatic	
Delusions of reference	**Avolition-Apathy:**
Delusions of mind reading	Impaired grooming and hygiene
Thought broadcasting	Lack of persistence at work or school
Thought insertion	Physical anergia
Thought withdrawal	
	Anhedonia-asociality:
Bizarre Behaviour:	Few recreational interests/activities
Clothing, appearance	Little sexual interest/activity
Social, sexual behaviour	Impaired intimacy/closeness
Aggressive-agitated	Few relationships with friends/peers
Repetitive-stereotyped	
	Attention:
Positive Formal Thought Disorder :	Social inattentiveness
Derailment	Inattentiveness during testing
Incoherence	
Illogicality	
Circumstantiality	
Pressure of speech	
Distractible speech	
Clanging	

7) Positive Symptoms

(1) Delusion

Delusion is a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture (e.g., it is not an article of religious faith). When a false belief involves a value judgement, it is regarded as a delusion only when the judgement is so extreme as to defy credibility. Delusional conviction occurs on a continuum and can sometimes be inferred from an individual's behaviour. It is often difficult to distinguish between a delusion and an overvalued idea (in which case the individual has an unreasonable belief or idea but does not hold it as firmly as is the case with a delusion).

Delusions are erroneous beliefs that usually involve a misinterpretation of perceptions or experiences. Their content may include a variety of themes (e.g., persecutory, referential, somatic, religious, or grandiose). Among them persecutory are most common in which one believes that he/she is being tormented, followed, tricked, spied on, or subjected to ridicule. Likewise referential delusions are also common in which a person believes that certain gestures, comments, passages from books, newspapers, song lyrics, or other environmental cues are specifically directed at him/her. We need to keep in mind that the distinction between delusion and strongly held belief is difficult to make out. Bizarre delusions are characteristics of schizophrenia; but it is difficult to judge, especially across different cultures. Any delusion is deemed bizarre if it is clearly implausible and not understandable and does not derive from ordinary life experiences. For example a man believes that his kidney was removed and replaced with someone else's kidney without any mark of surgery. It is a bizarre delusion. A nonbizarre delusion will be to believe that someone is keeping track of one's movements. Bizarre delusions will also mean those that express loss of control over mind or body (they are among the 'first-rank symptoms' of Schneider) which are one's belief that his/her thoughts have been taken away by some outside force ('thought withdrawal'), or that alien thoughts have been put into his or her mind ('thought insertion'), or that his/her body or actions are being acted on or manipulated by some outside force ('delusion of control').[10]

a. Varied Content in Delusions[11]

Varied Content in Delusions	
Delusions	Foci of Preoccupation
Grandiose	Possessing wealth, great beauty, or having a special ability (e.g., extrasensory perception); having influential friends; being an important figure (e.g., Napoleon, Hitler)
Nihilistic	Belief that one is dead or dying; belief that one does not exist or that the world does not exist
Persecutory	Being persecuted by friends, neighbours, or spouses; being followed, monitored, or spied on by the government (e.g., FBI, CIA) or other important organizations (e.g., the Catholic Church)

Somatic	Belief that one's organs have stopped functioning (e.g., that the heart is no longer beating) or are rotting away; belief that the nose or other body part is terribly misshapen or disfigured
Sexual	Belief that one's sexual behaviour is commonly known; that one is a prostitute, a paedophile, or a rapist; that masturbation has led to illness or insanity
Religious	Belief that one has sinned against God; that one has a special relationship to God or some other deity; that one has a special religious mission; that one is the Devil or is condemned to burn in Hell

(2) Hallucination

Hallucination is a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. It is different from illusion in which an actual external stimulus is misperceived or misinterpreted. The person may or may not have insight into the fact that he/she is having a hallucination. One person with auditory hallucinations may recognize that he/she is having a false sensory experience, whereas another may be convinced that the source of the sensory experience has an independent physical reality. False perception that occur during dreaming, while falling asleep (hypnagogic), or when awakening (hypnopompic) are not considered hallucinations. Transient hallucinatory experience may occur in people without mental disorder.

a. Hallucination in Sensory Modality

Hallucinations may occur in any sensory modality (e.g., auditory, visual, olfactory, gustatory, and tactile). Among them auditory hallucinations are the most common and characteristic of schizophrenia. They are mostly voices either familiar or unfamiliar perceived as distinct from the person's own thoughts whose content may be quite variable although pejorative or threatening voices are especially common. Two or more voices conversing with one another or voices maintaining a running commentary on the person's thoughts or behaviour have been considered to be particularly characteristic of schizophrenia and were included among Schneider's list of first-rank symptoms. Finally it is to be noted

that hallucinations must occur in the context of a clear sensorium; those that occur while falling asleep (hypnagogic) or waking up (hypnopompic) are not considered since those are within the range of normal experience. Isolated experiences of hearing one's name called or experiences that lack the quality of an external percept (e.g., humming in one's head) are also not considered to be hallucinations characteristic of schizophrenia. Hallucinations can also be a normal part of religious experience in cultural contexts.[12]

(3) Disorganized Speech

Disorganized thinking ('formal thought disorder,' 'loosening of associations'), though an important symptom, is difficult to be defined as 'thought disorder.' One can infer thought disorder primarily from the speech of the individual. That is why in the diagnosis, disorganized speech becomes a criterion. The disorganized speech could be in very many ways. An individual may 'slip off the track' from one topic to another ('derailment' or 'loose associations'); answers to questions may be obliquely related or completely unrelated ('tangentiality'); and at times speech may be so severely disorganized that it is nearly incomprehensible and resembles aphasia in its linguistic disorganization ('incoherence' or 'word salad').[13]

(4) Grossly Disorganized Behaviour

Grossly disorganized behaviour may manifest itself in a variety of ways ranging from childlike silliness to unpredictable agitation. Problems may be in any form of goal-directed behaviour which involves difficulties in performing activities of daily living such as maintaining hygiene; may appear markedly dishevelled, may dress in an unusual manner (e.g., wearing multiple overcoats on a hot day), may display inappropriate sexual behaviour like masturbating in public or demonstrate unpredictable and untriggered agitation (e.g., shouting or swearing). One should be careful in distinguishing grossly disorganized behaviour from merely aimless or generally unpurposeful and from organized behaviour that is motivated by delusional beliefs. Likewise a few instances of restless, angry, or agitated behaviour are not evidence of schizophrenia especially if the motivation is understandable.

Catatonic motor behaviours include a marked decrease in reactivity to the environment, sometimes reaching an extreme degree of complete unawareness (catatonic stupor), maintaining a rigid posture and resisting efforts to be moved (catatonic rigidity), active resistance to instructions or attempts to be moved (catatonic negativism), the assumption of inappropriate or bizarre postures(catatonic posturing), or purposeless and unstimulated excessive motor activity (catatonic excitement). One should remember that catatonic symptoms are nonspecific and may occur in other mental disorders as in Mood Disorders With Catatonic Features.[14]

8) Negative Symptoms

Let us consider the negative symptoms of affective flattening, alogia, and avolition. Affective flattening is specially common and the person's face may appear immobile and unresponsive, with poor eye contact and reduced body language. Though the person may smile once in a way, the range of emotional expressiveness is clearly diminished most of the time. Alogia (poverty of speech) is manifested by brief, laconic, empty replies. The patient may have a diminution of thoughts that is reflected in decreased fluency and productivity of speech. Avolition is an inability to initiate and persist in goal-directed activities. One may sit for long periods of time and show little interest in participating in work or social activities.

Criterion A for schizophrenia requires that at least two of the five items be present concurrently for much of at least one month. However, if delusions are bizarre or hallucinations involve 'voice commenting' or 'voices conversing,' then the presence of only one item is required. The presence of this relatively severe constellation of signs and symptoms is referred to as the 'active phase.' In those situations in which the active-phase symptoms remit within a month in response to treatment, Criterion A can still be considered to have been met if the clinician judges that the symptoms would have persisted for a month in the absence of effective treatment.[15]

9) Specifiers[16]

Specifiers are used to indicate the characteristic course of symptoms of schizophrenia over time.

Episode With Interepisode Residual Symptoms: This applies when the course is characterized by episodes in which Criterion A is met and there are clinically significant residual symptoms between the episodes.

With Prominent Negative Symptoms: This can be added if prominent negative symptoms are present during these residual periods.

Episodic With No Interepisode Residual Symptoms: This applies when the course is characterized by episodes in which Criterion A is met and there are no clinically significant residual symptoms between episodes.

Continuous: This applies when characteristic symptoms of Criterion A are met throughout (or most) of the course. With Prominent Negative Symptoms can be added if they are present.

Single Episode In Partial Remission: This applies when there has been a single episode in which Criterion A is met and some clinically significant residual symptoms remain. With Prominent Negative Symptoms can be added if these residual symptoms include those symptoms.

Single Episode In Full Remission: This applies when there has been a single episode in which Criterion A is met and no clinically significant residual symptoms remain.

Other or Unspecified Pattern: This is used if another or unspecified course pattern has been present.

10) Other Symptoms

Lack of Insight

Lack of insight is common in schizophrenia. Individuals often deny they are ill or abnormal, and insist their hallucinations and delusions are real. The poor insight usually persists. Orientation and memory are preserved, unless impaired by the patient's psychotic symptoms, inattention or distractibility.

Soft Signs

Nonlocalizing soft signs occur in a substantial proportion of schizophrenic patients. This includes abnormalities in stereognosis, graphesthesia, balance, and proprioception. Their presence

may reflect dysfunction in areas of motor coordination, integrative sensory function, and ordering complex motor tasks.

Ocular Symptoms

Individuals usually display an abnormal smooth pursuit eye movement (SPEM). It is a disorder of the visual tracking of smoothly moving targets. Some believe that abnormal SPEM may represent a biological marker for the patient, since it has been observed in patients with remitted schizophrenic and schizotypal personality disorder and is frequently found in relatives of schizophrenic patients.

Vegetative Functions

In some patients, there is disturbance of sleep, sexual interest, or other bodily functions. Patients often have little interest in sexual activity and may derive little or no pleasure from sexual experiences.

Immune System Function

Disturbed immune functioning has been reported in schizophrenia.

Premorbid Personality

Patients with schizophrenia often have abnormal premorbid personalities. About 44% of the personality disorders are schizoid, and the rest are a mixture of avoidant, paranoid, histrionic, compulsive, and other personality disorders.[17]

11) Prevalence, Course, and Familial Pattern

The prevalence of schizophrenia is usually estimated to be between 0.5% and 1%. The median age at onset for the first psychotic episode of schizophrenia is in the early to mid-20s for men, and in the late 20s for women. The onset may be abrupt or insidious, but the majority of patients display some type of prodromal phase manifested by the slow and gradual development of a variety of signs and symptoms. Eventually the appearance of some active-phase symptom marks the disturbance as schizophrenia. Most studies on course and outcome suggest that the course may be variable, with some displaying exacerbations and remissions, whereas others remain chronically ill. Of those who remain ill, some appear to have a relatively stable course, whereas others show

a progressive worsening associated with severe disability. Early in the illness, negative symptoms may be prominent, appearing primarily as prodromal features. Subsequently positive symptoms appear. Since positive symptoms are particularly responsive to treatment, they typically diminish, but in many individuals, negative symptoms persist between episodes of positive symptoms. The first-degree biological relatives of individuals have a risk for schizophrenia that is about 10 times greater than that of the general population.[18]

12) Differential Diagnosis[19]

The diagnosis of schizophrenia should be thought of as a diagnosis of exclusion, because none of its clinical features are pathognomonic. Schizophrenia remains a clinical diagnosis that rests on historical information and a careful mental status examination, and there are no predictable laboratory abnormalities that are diagnostic of the disorder. The first thing to be done in diagnosis is to take a careful history and perform a physical examination to exclude psychoses due to known medical causes. For example, psychotic symptoms have been known to result from substance abuse; intoxication due to commonly prescribed medications; infectitious, metabolic, and endocrine disorders; tumours and mass lesions; and temporal lobe epilepsy. Routine lab tests may be helpful in ruling out potential medical causes. The major task in differential diagnosis involves separating schizophrenia from schizoaffective disorder, mood disorder with psychotic features, delusional disorder, or a personality disorder.

In Common with	Characteristics Shared	Exclusively characteristic of Schizophrenia or of the disorder with which it is compared or the difference between the two disorders
Mood Disorder With Psychotic Features and Schizoaffective Disorder	Mood disturbance	Here major depressive or manic episodes are present during the active phase or the mood episode is prolonged; but in Schizophrenia – major depressive or manic episodes should have been absent during the active phase, or the mood episode should have been brief relative to the total duration of the psychotic episode

Delusional Disorder	Delusions, and hallucinations	Schizophrenia – has bizarre delusions, and hallucinations
Personality Disorder – eccentric cluster (e.g., Schizoid, Schizotypal, and Paranoid Personality)	Indifferent to social relationships and display restricted affect, may have bizarre ideation and odd speech, or may be suspicious and hypervigilant	Schizophrenia – in addition to the common traits, has delusions, hallucinations, or grossly disorganized behaviour, thought disorder, behavioural disturbances, and enduring personality deterioration
Depersonalisation Disorder and sometimes Panic Disorder	Feeling of unreality, such as that one's mind and body are separate	Unlike schizophrenia, insight is well preserved, and hallucinations and delusions are absent.
Obsessive-Compulsive Disorder	Rituals	Obsessive-compulsive – rituals result in bizarre behaviour and they are performed to relieve anxiety; Schizophrenia – rituals result in response to delusional beliefs
Schizophreniform	Psychotic symptoms	Schizophreniform - Less than six months

13) Schizophrenia Subtypes

The main purpose of subtyping is to improve predictive validity, to help the clinician to select treatments and predict outcome. But these promises remain unfulfilled, and the reliability and validity of different schizophrenic subtypes are not fully established. All the same, as a practical matter, many patients seem to fit the subtypes. DSM-IV recognizes five subtypes of schizophrenia: 1) paranoid, 2) disorganized, 3) catatonic, 4) undifferentiated, and 5) residual.[20]

(1) Paranoid Type[21]

(DSM-IV Code: 295.30 & ICD-10 Code: F20.0x)

Diagnostic Criteria for Paranoid Type

A type of schizophrenia in which the following criteria are met:

A. Preoccupation with one or more delusions or frequent auditory hallucinations.

B. None of the following is prominent: disorganized speech, disorganized or catatonic behaviour, or flat or inappropriate affect.

It was Kraepelin who first identified subtype of schizophrenia, in which patients had bizarre and fragmented delusions and, ultimately, personality deterioration. This type is mentioned in all the DSM editions. Patients with paranoid schizophrenia have an older age at onset, better premorbid functioning, and a better outcome. They are more likely to marry and have better occupational functioning than patients with other subtypes.

(2) Disorganized Type[22]

(DSM-IV Code: 295 & ICD-10 Code: F20.1x)

Disorganized schizophrenia was first described in 1871 by Ewald Hecker, who used the term hebephrenia. It is characterized by disorganized speech and behaviour, and flat or inappropriate affect. However it does not meet criteria for catatonic schizophrenia. Generally, delusions and hallucinations, if present, are fragmentary, unlike the well-systematized delusions of the paranoid schizophrenic. Typically it has an early onset that begins with the insidious development of avolition, affective flattening, deterioration of habits, and cognitive impairment, as well as delusions and hallucinations. Patients are also reported to have a greater family history of psychopathology, poorer premorbid functioning, and poorer long-term prognosis with continuous illness than patients with paranoid schizophrenia. Clinically they seem silly and childlike and sometimes grimace or giggle inappropriately or appear self-absorbed. Mirror gazing is commonly described in these patients.

Diagnostic Criteria for Disorganized type

A type of schizophrenia in which the following criteria are met:

A. All of the following are prominent:
   (1) disorganized speech
   (2) disorganized behaviour
   (3) flat or inappropriate affect
B. The criteria are not met for catatonic type.

(3) Catatonic Schizophrenia[23]

(DSM-IV Code: 295.20 & ICD-10 Code: F20.2x)

It was Karl Kahlbaum who used the term catatonia in 1874 to describe a disorder with abnormal motor, sensory, and verbal symptoms including vergigeration, mutism, negativism, and stereotyped movements, waxy flexibility, and decreased sensitivity to pain. Later Kraepelin and Bleuler considered catatonic a subtype of schizophrenia. Catatonic schizophrenia is defined by DSM-IV as dominated by at least two of the following: motoric immobility as evidenced by catalepsy or stupor, extreme agitation, extreme negativism, or mutism, peculiarities of voluntary movements (e.g., stereotypes, mannerisms, grimacing), and echolalia, or echopraxia. In comparison with other subtypes, patients with catatonic schizophrenia tend to have the earliest age at onset, the most chronic course, and the poorest social and occupational functioning. This type is becoming less common in developed countries.[24]

Diagnostic Criteria for Catatonic Type

A type of schizophrenia in which the clinical picture is dominated by at least two of the following:

(1) motoric immobility as evidenced by catalepsy (including waxy flexibility) or stupor
(2) excessive motor activity (that is apparently purposeless and not influenced by external stimuli)
(3) extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism

(4) peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures) stereotyped movements, prominent mannerisms, or prominent grimacing
(5) echolalia or echopraxia

Differential Diagnosis

Isolated catatonic symptoms are often found in other subtypes of schizophrenia, in other psychotic disorders, and in medical illnesses such as a viral encephalitis, frontal lobe tumours, metabolic disturbances (e.g., acute intermittent porphyria), and toxic reactions. Intravenous sodium amobarbital may be helpful in the differential diagnosis of catatonia. Perry and Jocobs (1982) reported that functional catatonia will clear temporarily during an 'Amytal interview,' (i.e., a mute patient may begin to speak). Patients in whom a catatonic syndrome has resulted from a medical disorder will become drowsy and less responsive.[25]

(4) Undifferentiated Type[26]

(DSM-IV Code: 295.90 & ICD-10 Code: F20.3x)

(DSM-IV includes the undifferentiated subtype, which is a residual category for patients meeting criteria for schizophrenia but not meeting criteria for the paranoid, disorganized, or catatonic subtypes. This subtype is the most widely diagnosed.)

The essential feature of the undifferentiated type of schizophrenia is the presence of symptoms that meet criteria A of schizophrenia but that do not meet criteria for the paranoid, disorganized, or catatonic type.

Diagnostic Criteria for Undifferentiated Type

A type of schizophrenia in which symptoms that meet criteria A are present, but the criteria are not met for the paranoid, disorganized, or catatonic type.

(5) Residual Type[27]

(DSM-IV Code: 295.60 & F20.5x)

The residual subtype as found in DSM-IV is applied to patients who no longer have prominent psychotic symptoms, but who once met criteria for schizophrenia and have continuing evidence of illness. Ongoing illness may be indicated by the presence of negative symptoms, or of two or more symptoms listed in criterion A for Schizophrenia present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

Diagnostic Criteria for Residual Type

A type of schizophrenia in which the following criteria are met:

A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behaviour.

B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in criteria A for Schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

(6) Summary of Subtypes[28]

DSM-IV Subtypes of Schizophrenia

Subtype	Criteria	Associated Features
1.Paranoid	Preoccupation with one or more delusions or frequent auditory hallucinations. None of the following is prominent: disorganized speech, disorganized or catatonic behaviour, flat or inappropriate affect.	Often associated with unfocused anger, anxiety, argumentativeness, or violence. Stilted, formal quality or extreme intensity of interpersonal interactions may be seen.
2.Disorganized	All of the following are prominent: 1. disorganized speech, 2. disorganized behaviour, 3. flat or inappropriate affect. The criteria are not met for catatonic type.	Silly and childlike behaviour is common; associated with extreme social impairment, poor premorbid functioning, and poor long-term functioning.

3.Catatonic	The clinical picture is dominated by at least two of the following: 1. Motor immobility as evidenced by catalepsy (including waxy flexibility) or stupor, 2. Excessive motor activity (that is apparently purposeless and not influenced by extreme stimuli),3.Extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism, 4.Peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing, 5. Echolalia or echopraxia	Marked psychomotor disturbance present (stupor or agitation), and unusual motor disturbance may be present. May need medical supervision due to malnutrition, exhaustion, hyperpyexia or self-injury. Sodium amobarbital interview may help in diagnosis.
4.Undifferentiated type	Symptoms meeting criterion A are present, but the criteria are not met for paranoid, disorganized,or catatonic types.	Probably the most common presentation in clinical practice.
5.Residual	The following criteria are met: Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behaviour. Continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in criterion A for schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences)	Active phase symptoms (i.e., psychotic symptoms) are not present, but patient still exhibits emotional blunting, eccentric behaviour, illogical thinking, and mild loosening of associations.

3. Schizophreniform Disorder

(DSM-IV Code: 295.40 & F20.8)

Gabriel Langfeldt introduced the term schizophreniform psychosis in 1939 to describe psychoses that were acute and reactive and occurred in persons with normal personalities. This term was introduced in 1980 into DSM-III to identify patients with a good prognosis, nonmood disorder distinct from schizophrenia. The current definition of schizophreniform disorder in DSM-IV requires active positive or negative symptoms and requires that the disorder is not due to a schizoaffective disorder or a mood disorder with psychotic features, is not substance induced or due to a general medical condition, and lasts more than 1 month but less than 6 months. The diagnosis changes to schizophrenia if symptoms extend past 6 months, even if the symptoms are residual. This can be further subdivided into cases with and without good prognostic features. Research has supported the validity of schizophreniform disorder as a distinct diagnosis. It is also found that the diagnosis identifies a heterogeneous group of patients. Follow-up studies show that the majority of schizophreniform patients eventually develop other psychiatric syndromes, including schizophrenia, mood disorders, or schizoaffective disorder. Clearly, the proper boundaries for schizophreniform disorder have not been established, so that the main use of the diagnosis is to guard against a premature diagnosis of schizophrenia. Treatment of schizophreniform disorder is similar to that of an acute episode of schizophrenia.

The essential features of schizophreniform disorder are identical to those of schizophrenia (criterion A) except for two differences: 1. the total duration of the illness (including prodromal, active, and residual phases) is at least 1 month but less than 6 months (criterion B) and, 2. impaired social or occupational functioning during some part of the illness is not required (although it may occur). Its duration is intermediate between that for brief psychotic disorder (in which symptoms last for at least 1 day but for less than 1 month) and schizophrenia (in which symptoms persist for at least 6 months). The diagnosis of schizophreniform disorder is made under two conditions. 1. The diagnosis is applied without qualification to an episode of illness of between 1 and 6 months' duration from which the individual has already recovered, 2. The

diagnosis is applied when a person who, although symptomatic, has been so for less than the 6 months required for a diagnosis of schizophrenia. In this case, the diagnosis of schizophreniform disorder should be qualified as 'provisional' because there is no certainty that the individual will actually recover from the disturbance within the 6-month period. If the disturbance persists beyond 6 months, the diagnosis would be changed to schizophrenia.[29]

1) Diagnostic Criteria[30]

Diagnostic Criteria for Schizophreniform Disorder

A. Criterion A, D, and E of schizophrenia are met.

B. An episode of the disorder (including prodromal, active, and residual phases) lasts at least 1 month but less than 6 months. (When the diagnosis must be made without waiting for recovery, it should be qualified as 'provisional.')

Specify if:

Without Good Prognostic Features

With Good Prognostic Features: as evidenced by two (or more) of the following:

(1) onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behaviour or functioning

(2) confusion or perplexity at the height of the psychotic episode

(3) good premorbid social and occupational functioning

(4) absence of blunted or flat affect

Unlike schizophrenia, impairment in social or occupational functioning is not required for a diagnosis of schizophreniform disorder even though most individuals do experience dysfunction in various areas of daily functioning (e.g., work or school, interpersonal relationships, and self-care). In developing countries, recovery from psychotic disorders may be more rapid, which would result in higher rates of schizophreniform disorder than of schizophrenia. Approximately one-third of individuals with an initial diagnosis of schizophreniform disorder (provisional) recover within the 6-months period and receive schizophreniform disorder as their final diagnosis. The remaining two-thirds will progress to the diagnosis of schizophrenia or schizoaffective disorder.

4. Schizoaffective Disorder

(DSM-IV Code: 295.70 & ICD-10 Code: F25.x)

In schizoaffective disorder there is an uninterrupted period of illness during which, at some time, there is a major depressive, manic, or mixed episode concurrent with psychotic symptoms characteristic of schizophrenia, and during the same period of illness there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms. Further, symptoms meeting criteria for a mood episode are present for a substantial part of the total duration of the active and residual periods of the illness. Schizoaffective disorder must be distinguished from schizophrenia on the one hand and psychotic mood disorders on the other.

1) Diagnostic Criteria

Diagnostic Criteria for Schizoaffective Disorder

A. An uninterrupted period of illness during which, at some time, there is either a Major Depressive Episode, a Manic Episode, or a Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia.

Note: The Major Depressive Episode must include Criterion A1: depressed mood.

B. During the same period of illness, there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms.

C. Symptoms that meet criteria for a mood episode are present for a substantial portion of the total duration of the active and residual periods of the illness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition.

Specify type:

Bipolar Type (ICD-10 Code: F25.0): if the disturbance includes a Manic or a Mixed Episode (or a Manic or a Mixed Episode and Major Depressive Episodes)

Depressive Type (ICD-10 Code: F25.1): if the disturbance only includes Major Depressive Episodes

The essential feature is (1) an uninterrupted period of illness during which, at sometime, there is (2) a Major Depressive, Manic, or Mixed Episode concurrent with symptoms that meet Criterion A for Schizophrenia. In addition, during the same period of illness, (3) there have been delusions or hallucinations for at least 2 weeks in the absence of prominent mood symptoms. To meet criteria for schizoaffective disorder, the essential features must occur within a single uninterrupted period of illness. The phrase 'period of illness' as used here refers to a time period during which the individual continues to display active or residual symptoms of psychotic illness. For some individuals the period of illness may last for years or even decades. The phase of the illness with concurrent mood and psychotic symptoms is characterized by the full criteria being met for both the active phase of schizophrenia and for a major depressive episode, a manic episode, or a mixed episode. The duration of the major depressive episode must be at least 2 weeks; the duration of the manic or mixed episode must be at least 1 week. Because the psychotic symptoms must have a total duration of at least 1 month to meet Criterion A for schizophrenia, the minimum duration of a schizoaffective episode is also 1 month.

The typical age at onset of schizoaffective disorder is probably early adulthood, although onset can occur anywhere from adolescence to late in life. The prognosis for schizoaffective disorder is somewhat better than the prognosis for schizophrenia, but considerably worse than the prognosis for mood disorders. There is an increased risk for schizophrenia in first-degree biological relatives of individuals with schizoaffective disorder.[31]

2) Differential Diagnosis[32]

In Common with	Characteristics Shared	Exclusively characteristic of Schizoaffective Disorder or of the disorder with which it is compared or the difference between the two disorders
Schizophrenia	Mood episode	Schizoaffective – the mood episode must be concurrent with the active-phase symptoms of schizophrenia. Mood symptoms must be present for a substantial portion of the total duration of the disturbance.

		Schizophrenia – mood symptoms either have a duration that is brief relative to the total duration of the disturbance, occur only during the prodromal or residual phases, or do not meet full criteria for a mood episode.
Delusional Disorder	Delusion	Delusional Disorder – the psychotic symptoms in delusional disorder are restricted to nonbizarre delusions.

5. Delusional Disorder

(DSM-IV Code: 297.1 & ICD-10 Code: F22.0)

Delusional disorders constitute a small but important group of conditions characterized by the presence of systematized, nonbizarre delusions accompanied by affect appropriate to the delusions. Personality is generally spared, but the delusion may preoccupy and dominate the patient's life.

1) Historical Overview

The term 'paranoid' was used by the Greeks nearly two 2,000 years ago to describe insanity or 'craziness' and can be literally translated as 'a mind beside itself.' In the early nineteenth century the term was reviewed by German psychiatrists who were interested in disorders characterized by delusions of persecution and grandeur. Karl Kahlbaum (1828-1899) first applied the term to a chronic delusional disorder. Kraepelin gradually altered the formulation of paranoia and by the eighth revision of his 'Lehrbuch der Psychiatrie' he had restricted the term to describe persons with systematized delusions, an absence of hallucinations, and a prolonged course without recovery but not leading to mental deterioration. Kraepelin also identified 'paraphrenia' as an intermediate group of paranoid disorders between dementia praecox and paranoia characterized by unremitting systematized delusions and hallucinations without progression to dementia. Both Kraepelin and Bleuler believed that paranoia was a condition distinct from dementia praecox, although unlike Kraepelin, Bleuler maintained that hallucinations occurred in some patients. Ernst Kretschmer (1888-1964) regarded paranoia as a psychogenic reaction occurring

in people with sensitive personalities rather than as an organic illness.

Delusional disorder, used in DSM-IV, resembles the definition put forth by Kraepelin in 1912 for paranoia. The original term for this condition, 'paranoid disorder,' which was used in DSM-III, has been abandoned because the word paranoid is usually construed to mean 'persecutory.' Because the delusions found in patients with delusional disorder are not restricted to persecutory themes, the former term was no longer believed appropriate. Kendler (1980) has further proposed that in the absence of hallucinations the term 'simple delusional disorder' be used, and that when hallucinations are present the term 'hallucinatory delusional disorder' be used.[33]

2) Diagnostic Criteria[34]

Diagnostic Criteria for Delusional Disorder

A. Nonbizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration.

B. Criterion A for Schizophrenia has never been met. Note: Tactile and olfactory hallucinations may be present in delusional disorder if they are related to the delusional theme.

C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behaviour is not obviously odd or bizarre.

D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods.

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify type (the following types are assigned based on the predominant delusional theme):

1. Erotomanic Type: delusions that another person, usually of higher status, is in love with the individual
2. Grandiose Type: delusions of inflated worth, power, knowledge, identity or special relationship to a deity or famous person

3. Jealous Type: delusions that the individual's sexual partner is unfaithful
4. Persecutory Type: delusions that the person (or someone to whom the person is close) is being malevolently treated in some way
5. Somatic Type: delusions that the person has some physical defect or general medical condition
6. Mixed Type: delusions characteristic of more than one of the above types but no one theme predominates
7. Unspecified Type

3) Subtypes

Erotomanic Type

In this type the central theme of the delusion is that another person is in love with the individual. It is an idealized romantic love and spiritual union rather than sexual attraction. The person about whom this conviction is had is usually of higher status known or unknown. Efforts to contact the object of the delusion through telephone calls, letters, gifts, visits, and even surveillance and stalking are common though at times patients keep the delusion secret.

Grandiose Type

In this type the central theme of the delusion is the conviction of having some great but unrecognised talent or insight or having made some important discovery. Less commonly, the individual may have the delusion of having a special relationship with a prominent person or being a prominent person. It may also have a religious content (e.g., belief that he/she has a special message from a deity).

Jealous Type

In this the central theme of the person's delusion is that his or her spouse or lover is unfaithful. This belief is arrived at without due cause and is based on incorrect inferences supported by small bits of 'evidence' which are collected and used to justify the delusion.

Persecutory Type

In this type the central theme of the delusion is the belief that he/she is being conspired against, cheated, spied on, followed,

poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. Often the focus could be on some injustice that must be remedied by legal action ('querulous paranoia') and the person may repeatedly attempt to appeal to the court for justice.

Somatic Type

In this type the central theme of delusion involves bodily functions or sensations. It may occur in several forms. Most common among them is the conviction that he/she emits a foul odour from the skin, mouth, rectum, or vagina; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are definitely (contrary to all evidence) misshapen or ugly; or that parts of the body are not functioning (e.g., the heart is not pumping blood).

Mixed Type

This subtype applies when no one delusional theme predominates.

Unspecified Type

This subtype applies when the dominant delusional belief cannot be clearly determined or is not described in the specific types (e.g., referential delusions without a prominent persecutory or grandiose component).[35]

The age at onset of delusional disorder is generally middle or late adult life, but can be at a younger age too.

4) Differential Diagnosis[36]

In Common with	Characteristics shared	Exclusively characteristic of Delusional Disorder or of the disorder with which it is compared or difference between the two disorders
Schizophrenia & Schizophreniform Disorder	Delusion	Delusional Disorder – delusions are nonbizarre and does not have the symptoms of the active phase of schizophrenia (e.g., prominent auditory or visual hallucinations, bizarre delusions, disorganized

		speech, grossly disorganized or catatonic behaviour, negative symptoms)
Hypochon-driasis	Fear of having a serious disease or the concern that one has such a serious disease	Hypochondriasis–holds the belief with less intensity
Body Dysmorphic Disorder	Preoccupation with some imagined defect in appearance	Body dysmorphic disorder – many individuals hold this belief with less intensity and recognize that their view of their appearance is distorted
Paranoid Personality Disorder	Delusion	Paranoid personality disorder – has no clear-cut or persisting delusional beliefs

6. Brief Psychotic Disorder

(DSM-IV Code: 298.8 & ICD-10 Code: F23.xx)

(with marked stressors. ICD-10 Code: F23.81; without marked stressors. ICD-10 Code: F23.80. They do not have DSM-IV codes.)

The essential feature of Brief Psychotic Disorder is a disturbance that involves the sudden onset of at least one of the following positive psychotic symptoms: delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), or grossly disorganized or catatonic behaviour. An episode of the disturbance lasts at least 1 day but less than 1 month, and the individual eventually has a full return to the premorbid level of functioning. The disturbance is not better accounted for by schizophrenia and is not due to the direct physiological effects of a substance (e.g., a hallucinogen) or a general medical condition (e.g., subdural hematoma).

1) Diagnostic Criteria

Diagnostic Criteria for Brief Psychotic Disorder

A. Presence of one (or more) of the following symptoms:

(1) delusions

(2) hallucinations

(3) disorganized speech (e.g., frequent derailment or incoherence)

(4) grossly disorganized or catatonic behaviour

Note: Do not include a symptom if it is a culturally sanctioned response pattern. For example, in some religious ceremonies, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the person's community.

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

C. The disturbance is not better accounted for by a Mood Disorder with Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effect of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Marked Stressor(s) (brief reactive psychosis) ICD-10 Code: F23.81: if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

Without Marked Stressor(s) ICD-10 Code: F23.80: if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

With Postpartum Onset: if onset within 4 weeks postpartum

Individuals with brief psychotic disorder typically experience emotional turmoil or overwhelming confusion. They may have rapid shifts from one intense affect to another. Although brief, the level of impairment may be severe, and supervision is required to ensure that nutritional and hygienic needs are met and that the individual is protected from the consequences of poor judgement,

cognitive impairment, or acting on the basis of delusions. There appears to be an increased risk of mortality (with a particularly high risk for suicide), especially among younger individuals. Pre-existing Personality Disorders (e.g., paranoid, histrionic, narcissistic, schizotypal, or borderline personality disorder) may predispose the individual to the development of the disorder.

This disorder is rather uncommon and may appear in adolescence or early adulthood, with the average age at onset being in the late 20s or early 30s. By definition, a diagnosis of brief psychotic disorder requires a full remission of all symptoms and a return to the premorbid level of functioning within 1 month of the onset of the disturbance. In some cases, the duration of psychotic symptoms may be quite brief (e.g., a few days).[37]

2) Differential Diagnosis[38]

In Common with	Characteristics shared	Exclusively characteristic of Brief Psychotic Disorder or of the disorder with which it is compared or difference between the two disorders
Schizophreniform Disorder, Delusional Disorder, Mood Disorder With Psychotic Features, Psychotic Disorder Not Otherwise Specified	Psychotic symptoms	This category of disorders have the duration of 1 month or longer compared to brief psychotic disorder
Factitious Disorder, with predominantly psychological signs and symptoms	Psychotic symptoms	The symptoms are produced intentionally compared to brief psychotic disorder
Malingering	Psychotic symptoms	In this the illness is feigned for an understandable goal compared to brief psychotic disorder
Personality Disorder	Brief period of psychotic symptoms	The symptoms are usually transient compared to brief psychotic disorder

7. Shared Psychotic Disorder (Folie à Deux)

(DSM-IV Code: 297.3 & ICD-10 Code: F24)

The essential feature of shared psychotic disorder is a delusion that develops in an individual who is involved in a close relationship with another person (sometimes termed the 'inducer' or 'the primary case') who already has a psychotic disorder with prominent delusions. The individual comes to share the delusional beliefs of the primary case in whole or in part. The delusion is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effect of a substance (e.g., amphetamine) or a general medical condition (e.g., brain tumour). Schizophrenia is probably the most common diagnosis of the primary case, although other diagnoses may include delusional disorder or mood disorder with psychotic features. The content of the shared delusional beliefs may be dependent on the diagnosis of the primary case and can include relatively bizarre delusions (e.g., satellite is emitting certain power that makes one constrained), mood-congruent delusions(e.g., that the individual will win a lottery that will make him the richest person), or the nonbizarre delusions that are characteristic of Delusional Disorder (e.g., that one is constantly under the police surveillance). Mostly the primary case in shared psychotic disorder is dominant in the relationship and gradually imposes the delusional system on the more passive and initially healthy second person(s). Individuals who come to share delusional beliefs are often related by blood or marriage and have lived together for a long time, sometimes in relative isolation. If the relationship with the primary case is interrupted, the delusional beliefs of the other individual usually diminish or disappear. Although most commonly seen in relationship of only two people, shared psychotic disorder can occur among a larger num-

ber of individuals, especially in family situations in which the parent is the primary case and the children, sometimes to varying degrees, adopt the parent's delusional beliefs. Besides the delusional beliefs, behaviour is usually not otherwise odd or unusual in shared psychotic disorder. Impairment is often less severe in the individual with shared psychotic disorder than in the primary case.

1) Diagnostic Criteria

Diagnostic Criteria for Shared Psychotic Disorder

A. A delusion develops in an individual in the context of a close relationship with another person(s), who has an already-established delusion.

B. The delusion is similar in content to that of the person who already has the established delusion.

C. The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

This disorder seems to be somewhat more common in women than in men. The age at onset is quite variable. Without intervention, the course is usually chronic, because this disorder most commonly occurs in relationships that are long-standing and resistant to change. With separation from the primary case, the individual's delusional beliefs disappear, sometimes quickly and sometimes quite slowly.[39]

8. Psychotic Disorder Due to a General Medical Condition

(DSM-IV Code: 293.3 & ICD-10 Code: F06.x)

(With delusions DSM-IV Code: 293.81 & ICD-10 Code: F06.2, With hallucinations DSM-IV Code: 293.82 & ICD-10 Code: F06.0.) (If both delusions and hallucinations are present, code whichever is predominant)

The essential features of psychotic disorder due to a general medical condition are prominent hallucinations or delusions that are judged to be due to the direct physiological effects of a general medical condition. Certainly there must be evidence from the history, physical examination, or laboratory findings that the delusions or hallucinations are the direct physiological consequence of a general medical condition.

1) Diagnostic Criteria

Diagnostic Criteria for Psychotic Disorder Due to a General Medical Condition

A. Prominent hallucinations or delusions.

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.

C. The disturbance is not better accounted for by another mental disorder.

D. The disturbance does not occur exclusively during the course of a delirium.

Specifiers:

With Delusions: if delusions are the predominant symptom

With Hallucinations: if hallucinations are the predominant symptom

In recording the disorder, the clinician should first note the presence of the psychotic disorder, then the identified general medical condition judged to be causing the disturbance, and finally the appropriate specifier indicating the predominant symptoms presentation (e.g., Psychotic Disorder Due to Thyrotoxicosis, With Hallucinations).

2) Associated General Medical Conditions

A variety of general medical conditions are known to cause psychotic symptoms, including 1. neurological conditions (e.g., neoplasms, cerebrovascular disease, Huntington's disease, epilepsy, auditory nerve injury, deafness, migraine, central nervous system infections), 2. endocrine conditions (e.g., hyper-and hypothyroidism, hyper-and hypoparathyroidism, hypoadrenocorticism), 3. metabolic conditions (e.g., hypoxia, hypercarbia, hypoglycemia), 4. fluid or electrolyte imbalances, 5. hepatic or renal diseases, and 6. autoimmune disorders with central nervous system involvement (e.g., systemic lupus erythematosus). The neurological conditions

that involve subcortical structures or the temporal lobe are more commonly associated with delusions.

Hallucination can occur in any sensory modality; but certain etiological factors are likely to evoke specific hallucinatory phenomena. Olfactory hallucinations, especially those involving the smell of burning rubber or other unpleasant smells, are highly suggestive of temporal lobe epilepsy. Hallucination may vary from simple and unformed to highly complex and organized. This disorder is not diagnosed if the individual maintains reality testing for the hallucination and appreciates that the perceptual experiences result from the general medical condition. Delusions may express a variety of themes, including somatic, grandiose, religious, and, most commonly, persecutory. Religious delusions have been specifically associated in some cases with temporal lobe epilepsy. Some people with right parietal brain lesions can develop a contralateral neglect syndrome in which they may disown parts of their body to a delusional extent. In general, associations between delusions and particular general medical conditions appear to be less specific than is the case for hallucinations.[40]

3) Differential Diagnosis[41]

In Common with	Characteristics Shared	Exclusively characteristic of Psychotic Disorder Due to a General Medical Condition or of the disorder with which it is compared or the difference between the two disorders
Primary Psychotic Disorder (e.g., Schizophrenia, Delusional Disorder, Schizoaffective Disorder) or a Primary Mood Disorder With Psychotic Features	Delusion or hallucination	These do not have any specific and direct causative physiological mechanisms associated with a general medical condition.

9. Substance-Induced Psychotic Disorder

The essential features of substance-induced psychotic disorder are prominent hallucinations or delusions that are judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure). Hallucinations that the individual realizes are substance induced are not included here and instead would be diagnosed as substance intoxication or substance withdrawal with the accompanying specifier With Perceptual Disturbances.

A substance-induced psychotic disorder is distinguished from a primary psychotic disorder by considering the onset, course, and other factors. For drugs of abuse, there must be evidence from the history, physical examination, or laboratory findings of intoxication or withdrawal. This disorder arises only in association with intoxication or withdrawal states, whereas primary psychotic disorders may precede the onset of substance use or may occur during times of sustained abstinence. Once initiated, the psychotic symptoms may continue as long as the substance use continues.[42]

1) Subtypes and Specifiers

One of the following subtypes may be used to indicate the predominant symptoms presentation. If both delusions and hallucinations are present, code whichever is predominant:

With Delusions: This subtype is used if delusions are the predominant symptom.

With Hallucinations: This subtype is used if hallucinations are the predominant symptom.

The context of the development of the psychotic symptoms may be indicated by using one of the specifiers listed below:

With Onset During Intoxication: This specifier should be used if criteria for intoxication with the substance are met and the symptoms develop during the intoxication syndrome.

With Onset During Withdrawal: This specifier should be used if criteria for withdrawal from the substance are met and the symptoms develop during, or shortly after, a withdrawal syndrome.[43]

2) Specific Substances

Psychotic Disorders can occur in association with intoxication with the following classes of substances: alcohol; amphetamine and related substances; cannabis; cocaine; hallucinogens; inhalants; opioids (meperidine); phencyclidine and related substances; sedatives, hypnotics, and anxiolytics; and other or unknown substances. Psychotic Disorders can occur in association with withdrawal from the following classes of substances: alcohol; sedatives, hypnotics, and anxiolytics; and other or unknown substances. The initiation of the disorder may vary considerably with the substance. For example, smoking a high dose of cocaine may produce psychosis within minutes, whereas days or weeks of high-dose alcohol or sedative use may be required to produce psychosis.[44]

3) Diagnostic Criteria[45]

Diagnostic Criteria for Substance-induced Psychotic Disorder

A. Prominent hallucinations or delusions. Note: Do not include hallucinations if the person has insight that they are substance induced.

B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):

   (1) the symptoms in Criterion A developed during, or within a month of, Substance Intoxication or Withdrawal

   (2) medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by a psychotic disorder that is not substance induced, the evidence of which might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication, or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence that suggests the existence of an independent non-substance-induced psychotic disorder (e.g., a history of recurrent non-substance-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Code (Specific Substance)-Induced psychotic Disorder:

291.5 Alcohol, With Delusions; 291.3 Alcohol, With Hallucinations; 292.11 Amphetamine (or Amphetamine-Like Substance), With Delusions; 292.12 Amphetamine (or Amphetamine-Like Substance), With Hallucinations; 292.11 Cannabis, With Delusions; 292.12 Cannabis, With Hallucinations; 292.11 Hallucinogen, With Delusions; 292.12 Hallucinogen, With Hallucinations; 292.11 Inhalant, With Delusions; 292.12 Inhalant, With Hallucinations; 292.11 Opioid, With Delusions; 292.12 Opioid, With Hallucinations; 292.11 Phencyclidine (or Phencyclidine-Like Substance), With Delusions; 292.12 Phencyclidine (or Phencyclidine-Like Substance), With Hallucinations; 292.11 Sedative, Hypnotic, or Anxiolytic, With Delusions; 292.12 Sedative, Hypnotic, or Anxiolytic, With Hallucinations; 292.12 Other (or Unknown) Substance, With Hallucinations)

Specify if

With Onset During Intoxication: if criteria are met for intoxication with the substance and the symptoms develop during the intoxication syndrome

With Onset During Withdrawal: if criteria are met for withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

4) Diagnoses Associated with Class of Substance[46]

Diagnoses Associated with Class of Substance

*Also Hallucinogen Persisting Perception Disorder (Flashbacks).

Note: X,I,W,I/W, or P indicates that the category is recognized in DSM-IV. In addition, I indicates that the specifier with Onset During Intoxication may be noted for the category (except for Intoxication Delirium); W indicates that the specifier With Onset During Withdrawal may be noted for the category (except for Withdrawal Delirium); and I/W indicates that either With Onset During Intoxication or With Onset During Withdrawal may be noted for the category. P indicates that the disorder is Persisting.

Substance	Dependence	Abuse	Intoxication	Withdrawal	Intoxicationan Delirium	Withdrawal Delirium	Dementia	Amnestic Disorder	Psychotic Disorders	Mood Disorders	Anxiety Disorders	Sexual Dysfunctions	Sleep Disorders
Alcohol	X	X	X	X	I	W	P	P	I/W	I/W	I/W	I	I/W
Amphetamines	X	X	X	X	I				I	I/W	I	I	I/W
Caffeine			X								I		I
Cannabis	X	X	X		I				I		I		
Cocaine	X	X	X	X	I				I	I/W	I/W	I	I/W
Hallucinogens	X	X	X		I				I*	I	I		
Inhalants	X	X	X		I		P		I	I	I		
Nicotine	X			X									
Opioids	X	X	X	X	I				I	I		I	I/W
Phencyclidine	X	X	X		I				I	I	I		
Sedatives, hypnotics, or anxiolytics	X	X	X	X	I	W	P	P	I/W	I/W	W	I	I/W
Poly substance	X												
Other	X	X	X	X	I	W	P	P	I/W	I/W	I/W	I	I/W

10. Psychotic Disorder Not Otherwise Specified

(DSM-IV Code: 298.9 & ICD-10 Code: F29)

This category includes psychotic symptomatology (i.e., delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour) about which there is inadequate information to make a specific diagnosis or about which there is contradictory information, or disorders with psychotic symptoms that do not meet the criteria for any specific psychotic disorder.

Examples include

1. Postpartum psychosis that does not meet criteria for Mood Disorder With Psychotic Features, Brief Psychotic Disorder, Psychotic Disorder Due to a General Medical Condition, or Substance-induced Psychotic Disorder
2. Psychotic symptoms that have lasted for less than 1 month but that have not yet remitted, so that the criteria for Brief Psychotic Disorder are not met
3. Persistent auditory hallucinations in the absence of any other features
4. Persistent nonbizarre delusions with periods of overlapping mood episodes that have been present for a substantial portion of the delusional disturbance
5. Situations in which the clinician has concluded that a Psychotic Disorder is present, but is unable to determine whether it is primary, due to a general medical condition, or substance induced[47]

11. Course of Schizophrenia

The course of schizophrenia can follow various patterns, although it is typically viewed as a chronic disorder that begins in late adolescence and has a poor long-term outcome. Its onset may be insidious or abrupt, although generally begins with a prodromal phase characterized by social withdrawal and other subtle changes in behaviour and emotional responsiveness. A patient may be seen as remote, aloof, emotionally detached, or even odd or eccentric. The onset of subtle thought disturbances and impaired attention may also occur at this stage. The prodrome varies in length, but typically lasts from months to years.

The prodrome is followed by an active phase in which psychotic symptoms predominate. At this point, clinical disorder becomes evident, and a diagnosis of schizophrenia can usually be made. This phase is characterized by florid hallucinations and delusions. A residual phase follows the resolution of the active phase and is similar to the prodrome. Psychotic symptoms may persist during this phase, but at a lower level of intensity, and they may not be as troublesome to the patient. Active-phase symptoms may occur episodically ('acute exacerbations') with variable levels of remission seen between episodes. The frequency and timing of these episodes are unpredictable, although stressful situations may precede these relapses or, in some instances, drug abuse. Through this process patients accrue increased levels of morbidity in the form of residual or persistent symptoms and decrements in function from their premorbid status. Relatively severe psychosis is continuous and unrelenting in some patients. There is a tendency for the symptoms of schizophrenia to evolve. Patients may show a preponderance of positive symptoms early in their illness, but gradually develop more negative or deficit symptoms. There is some evidence that schizophrenia may plateau at about 5 years without further deterioration.[48]

12. Outcome of Schizophrenia[49]

In summary, outcome studies show that schizophrenia is a devastating illness that affects every aspect of a patient's life. All the same, many patients with schizophrenia will have a relatively good outcome and will avoid the severe deterioration.

Features associated with good and poor outcome in schizophrenia

Feature	Good Outcome	Poor Outcome
Onset	Acute	Insidious
Duration	Short	Chronic
Psychiatric history	Absent	Present
Affective symptoms	Present	Absent
Sensorium	Clouded	Clear
Obsessions/compulsions	Absent	Present
Assaultiveness	Absent	Present
Premorbid functioning	Good	Poor
Marital history	Married	Never Married
Psychosexual functioning	Good	Poor
Neurological functioning	Normal	Soft signs present
Neuropsychological test results	Normal	Abnormal
Structural brain abnormalities	None	Present
Social class	High	Low
Family history of schizophrenia	Negative	Positive

Schizophrenia typically begins in early adulthood, but can develop at any age including early childhood. One study indicated that the mean age at onset is 21.4 years for men and 26.8 years for women. Patients are more likely to remain single and unmarried than are patients in other diagnostic groups. Patients generally have a low social status. Research has long shown increased mortality in patients with schizophrenia. They are at high risk for suicidal behaviour. Unlike other psychiatric patients who commit suicide, schizophrenic patients may fail to communicate their suicidal intentions and may act impulsively. Recent studies show that schizophrenic patients and other severe mental disorders exhibit relatively high rates of violent behaviour and criminality. Summaries of individual family studies have shown siblings of schizophrenic patients to have a near 10% lifetime risk of developing schizophrenia, while children who have one parent with schizophrenia have a 5%-6% lifetime risk.

13. Clinical Management

Antipsychotic medication has been the mainstay of treatment for schizophrenia since chlorpromazine was introduced in 1952. Many conventional antipsychotic drugs are now available, each differing in potency and side effects, but similar in mode of action and efficacy. With the exception of the new atypicals, no conventional antipsychotic has been shown to be superior to other. There is no evidence to support using a specific agent for a specific subtype of schizophrenia, nor is there any benefit from prescribing more than a single antipsychotic at a time. The majority of acutely psychotic schizophrenic patients will respond to a daily dose between 10 and 15 mg of haloperidol (or its equivalent) within several days or weeks. Higher dosages of conventional antipsychotics

may be needed in some patients but there is no evidence to support an advantage to either rapid loading or sustained high dosages. Highly agitated patients should be given frequent, equally spaced doses of an antipsychotic drug. Patients benefiting from short-term treatment with antipsychotic medications are candidates for long-term prophylactic treatment, which has as its goal the sustained control of psychotic symptoms.[50]

14. Physical Treatment

1) Electroconvulsive Therapy (ECT)

Electroconvulsive therapy has been found primarily to benefit those with mood disorders. Yet it is still widely used in the treatment of schizophrenia. ECT is effective in acute and subacute forms of schizophrenia, but rarely helpful in chronic cases. Its primary usefulness is in the treatment of a few specific syndromes and in patients not responding to antipsychotic medication. Catatonia and depression secondary to schizophrenia have both been recognized as indications for ECT, though this phenomenon has not been carefully studied. Other physical treatments like insulin coma therapy, psychosurgery and hemodialysis have failed to show any benefit to the patients.[51]

15. Psychosocial and Programmatic Intervention

Like antipsychotic medication, psychosocial treatment should be tailored to fit the schizophrenic patients' needs. A greater emphasis is placed on outpatient management and brief hospital stays. Hospitalisation is reserved for schizophrenic patients who pose a danger to themselves or others. An active ward milieu is superior to a custodial one in the hospital, especially if well structured and not overly stimulating. The following characteristics have been found optimal: small units, short stays, high staff to patient ratio, low staff turnover, low percentage of psychotic patients, broad delegation of responsibility with clear lines of authority, low perceived levels of anger and aggression, high levels of support, and a practical problem-solving approach. Patients not needing to be hospitalised may still benefit from the structure provided in day treatment or partial hospital programmes, especially patients with substantial symptoms who have not responded adequately to medication. These programmes generally operate weekdays, with patients returning home on evenings and weekends. Psychopharma-

cologic management is provided along with psychosocial rehabilitation. With most programmes, the services provided and frequency of attendance will be individualized to fit the needs of the patient.

Alcohol and other drug abuse is a significant problem for many schizophrenic patients. Substance abuse or dependence aggravates the symptoms of schizophrenia, leads to medication noncompliance, and undermines other treatment interventions. Abstinence should be encouraged in all patients, and some will need referral for drug detoxification and rehabilitation.

'Psychosocial rehabilitation' is a term used to describe services that aim to restore the patient's ability to function in the community. This may involve the medical and psychosocial treatments and ways to foster social interaction, to promote independent living, and to encourage vocational performance. Patients are encouraged to become involved in developing and implementing their rehabilitation plan, which has as its focus enhancing the patient's talents and skills. The goal of psychosocial rehabilitation is to integrate the patient back into his/her community, rather than segregating the patient in separate facilities. There are also organizations that serve a variety of functions including providing job training, social and leisure time activities, residential assistance, and skills training. Appropriate and affordable housing should be provided for the patients. The options may range from supervised shelters and group homes ('halfway houses') to boarding homes to supervised apartment living. Group homes provide peer support and companionship, along with on-site staff supervision. Of course persons with greater levels of impairment may need round-the-clock supervision in a nursing home.

Vocational training and support can also be of enormous benefit to schizophrenic patients in helping to mainstream them back into the community. Vocational interventions can be effective in helping patients find and maintain paid jobs. It may involve supported employment, competitive work in integrated settings, and more formal job training programmes. A simple, repetitive job environment offering both interpersonal distance and on-site supervision may be the best initial setting, such as that found in a 'sheltered workshop.' Though some patients will not be employable in any setting because of apathy, amotivation, or chronic psychosis, employment should be encouraged in able patients. A

job will serve to improve self-esteem, provide additional income, as well as provide a social outlet for the patient. Gradually the patient may move toward a more demanding work setting. Failure might diminish a patient's already shaky self-esteem and reinforce the 'sick' role. In some countries 'assertive community treatment' (ACT) is available, which consists of the careful monitoring of patients, the availability of mobile mental health teams, and aggressive programming individually tailored to each patient. ACT involves teaching patients basic living skills, helping patients work with community agencies, and helping them develop a social support network.[52]

16. Psychotherapies

Token economies in which patients are provided a high degree of ward structure and are rewarded for desired behaviours seem to be effective in controlling behaviour in the hospital, but this improvement often does not generalize to situations outside the hospital. Group therapy is frequently used with schizophrenic patients in the hospital to provide emotional support in a setting where a patient can learn social skills, and where friendships can develop. Inpatient groups that are most successful are highly structured and set limited goals. Traditional group therapy approaches that encourage self-exploration and the seeking of insight are generally countertherapeutic. This is particularly true with psychotic or highly paranoid individuals who might misinterpret situations that arise in group therapy.[53]

1) Cognitive Therapy Techniques[54]

(1) Cognitive Rehabilitation

Cognitive rehabilitation has as its goal the remediation of abnormal thought processes known to occur in schizophrenia; it uses techniques pioneered in the treatment of brain-injured persons. Here the focus is on improving information processing skills such as attention, memory, vigilance, and conceptual abilities. This may help improve performance on specific tasks but whether improvement on specific tasks can generalize to other situations needs further study.

(2) Cognitive Content

Content approaches focus on changing the schizophrenic

patient's abnormal thoughts (e.g., delusions) or his response to them or to his abnormal experiences (e.g., hallucinations). Patients learn various coping strategies such as listening to music to mask auditory hallucinations or reality testing of delusional beliefs. While these techniques appear promising as a way to reduce residual psychotic symptoms, more research is needed to learn which techniques are most effective.

2) Social Skills Training

Social and interpersonal skills are generally deficient in schizophrenic patients. Social skills training aims to help the patient develop more appropriate behaviour. This is accomplished by using modelling and social reinforcement and by providing opportunities, both individual and group, to practice the new behaviours. This could be as simple as helping the patient learn to maintain eye contact or as complicated as helping the patient learn conversational skills. Social skills training can significantly enhance social functioning, but probably has little effect on risk of relapse. The best results appear to occur in early onset schizophrenic patients whose social development would have been disrupted by the emergence of illness and in persons who persist in a training programme for more than 1 year.[55]

17. Conclusion

Tremendous progress has been made during the last 25 years to better our understanding of schizophrenia. While the introduction of DSM-III criteria in 1980 narrowed the definition for schizophrenia and created a more homogeneous group of subjects for research, some experts believed the narrowing went too far. A reemphasis on negative symptoms of schizophrenia (Bleuler's 'fundamental' symptoms) in DSM-IV has added balance to the perhaps too-rigid emphasis on Schneiderian symptoms in the 1970s. Advances in classification and epidemiology have allowed us to reevaluate the distribution of schizophrenia and its risk factors.

The development of brain-imaging techniques such as CT, MRI, SPECT, and PET have enhanced our understanding of schizophrenia. This technology is allowing us to explore the nature and pattern of brain deficits and examine the possibility of symptom localization in schizophrenia. The development of 'brain banks' as well as new techniques in histopathology have given renewed

emphasis to postmortem research, permitting a more detailed investigation of abnormalities in neurotransmitter systems and in the neuropathology of schizophrenia. While the nosologists and neuroscientists have been clarifying the classification and pathologic mechanisms of schizophrenia, geneticists have been amassing large family data sets and applying new methods such as gene mapping that promise to enrich the study of genetic factors in schizophrenia.

While technological advances are helping us to explore the aetiology of schizophrenia, knowledge about course and outcome has been enhanced through long-term studies. Now it is understood that the best treatment approach to schizophrenia combines pharmacological and psychosocial measures. The pharmacological treatment of schizophrenia has unduly relied on the well-worn dopamine theory, and investigators are now looking at other neurotransmitter systems that may yield a more complex interactive model of neurotransmission abnormalities that will result in new pharmacological approaches. Now newer atypical antipsychotics have become available, helping many patients formerly thought to be treatment refractory to achieve better functioning in the community. New research has highlighted the importance of family interaction models in schizophrenia, leading to more specific psychosocial interventions in the treatment of this disorder. During the 1990s, the 'Decade of the Brain,' the drive in psychiatry has been to develop a comprehensive understanding of brain function at levels that range from mind to molecule and to determine how aberrations in these normal functions lead to the development of symptoms of mental illness. Let us hope that the progress in the coming years will enhance our understanding of the pathophysiology and aetiology of schizophrenia and help treat patients better and if possible prevent its development.[56]

18. Decision Tree for Differential Diagnosis[57]

Differential Diagnosis of Psychotic Disorders

Delusions, hallucinations, disorganized speech or grossly disorganized behaviour.

1. Are they due to the direct physiological effects of a general medical condition?

If yes, then it is Psychotic Disorder Due to a General Medical Condition.

2. If no to the 1st question, then are they due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or a toxin)?

   If yes, then it is Substance-Induced Psychotic Disorder.

3. If no to the 2nd question, are there symptoms of active phase of Schizophrenia, lasting at least 1 month?

   If yes, then is there Major Depressive or Manic Episode concurrent with active-phase symptoms?

   If no, is the duration at least 6 months?

   If the duration is at least 6 months then it is Schizophrenia.

   If the duration is not at least 6 months then it is Schizophreniform Disorder.

   Are there 2 weeks of delusions or hallucinations in the absence of prominent mood symptoms?

   If yes, then it is Schizoaffective Disorder.

   If no, then it is Mood Disorder With Psychotic Features.

4. If no to the 3rd question, are there nonbizarre delusions lasting at least 1 month?

   If yes, is it evident that apart from delusions, the functioning is not markedly impaired?

   If yes, then it is Delusional Disorder.

   If no, then it is Psychotic Disorder NOS.

   If delusions occur only during mood episodes then it is Mood Disorder With Psychotic Features.

5. If no to the 4th question, is the duration more than 1 day but less than 1 month?

   If yes, then it is Brief Psychotic Disorder.

   If no, then it is Psychotic Disorder NOS.

3
MOOD DISORDERS

1. Introduction

Attempts to classify depression date back to at least the fourth century B.C., when Hippocrates coined the terms 'melancholia' (black bile), and 'mania' (to be mad). The independent descriptions in 1854 by two French physicians, Falret and Baillarger, of 'folie circulaire' and 'la folie à double forme' were the first formal diagnoses of alternating episodes of mania and depression as a single disorder. At the beginning of the current century, Emil Kraepelin differentiated schizophrenia (dementia praecox) from 'manic-depressive insanity' on the basis of a deteriorating course of the former and an episodic course of the latter. Kraepelin (1921) believed that manic-depressive insanity was a single illness that included 'periodic and circular insanity,' mania, and melancholia. Many of Kraepelin's observations of the symptoms and course of mood disorders remain accurate, but manic-depressive (bipolar) disorder is now known to be a complex group of disorders that share features such as a high rate of recurrence and alternations of mood states but differ in other important respects.

In USA, the first edition of DSM, Diagnostic and Statistical Manual: Mental Disorders (American Psychiatric Association 1952) reflected the influence of Adolph Meyer. Meyer believed that psychiatric disorders were reactions to conflict or stress that were more specific to the individual than to the illness. Psychotic mood disorders (e.g., psychotic depressive reaction) were diagnosed on the basis not of hallucinations and delusions but of its severity and the lack of a precipitant.

In DSM-II (American Psychiatric Association 1968), involutional melancholia and manic-depressive psychosis were added. The concept of a depressive reaction was maintained as depressive neurosis, which was considered a neurotic reaction to an internal conflict or external event. In the absence of a precipitant, a diagnosis

of psychotic depressive reaction was made for a single episode and manic-depressive psychosis for recurrent depressive episodes, whether or not the patient met traditional criteria for psychosis in use by most clinicians. Alternating depression and elation was called 'cyclothymia,' which was classified with the personality disorders on the grounds that it was chronic and was not caused by a specific circumstance. In subsequent editions of DSM, mood disorder diagnoses are based on symptom clusters rather than the presence or absence of one identifiable precipitant, since the presence of a precipitant does not demonstrably affect the course or treatment response of mood disorders.[1]

2. Endogenous and Reactive Depression

The differentiation of depression according to whether a precipitant is present is derived from an early distinction between endogenous (vital or melancholic) and reactive depression. In its original use by German descriptive psychiatrists, the term 'reactive' referred to a depressed patient's ability to react positively to interactions and events and thus implied the presence of milder symptomatology. But when the term was translated into English, it came to mean depression that developed in reaction to some external stress, thus implying an association between mild depression and depression in response to stress. In DSM-II, this concept was conserved as 'neurotic depressive reaction.' In later informal diagnostic schemes, milder forms of depression that are more responsive to the environment evolved into the concept of 'hysteroid dysphoria,' which is a type of depression with atypical symptoms that occurs in a patient with interpersonal sensitivity and a characterological tendency to dramatize. In DSM-III-R (American Psychiatric Association 1987) and DSM-IV (American psychiatric Association 1994a), the term 'atypical depression' (a modifier of a major depressive episode) is more or less equivalent to 'hysteroid dysphoria' and the modern derivative of neurotic depression.

Atypical depression is distinguished by mood reactivity (i.e., the capacity to be cheered up temporarily by positive reactions or events) as well as by severe fatigue (leaden paralysis), sensitivity to rejection, self-pity, a reverse diurnal mood swing (depression is worse later in the day), and reverse vegetative symptoms (e.g., increased instead of deceased appetite and sleep). About 15% of depressive episodes have atypical features. Atypical symptoms are more common in bipolar depression. Atypical depression appears to respond better to monoamine oxidase inhibitor (MOAI) antidepressants than to other antidepressants.

In contrast to reactive depression, the term 'endogenous depression' referred in German literature to depression that was unresponsive to the environment and in the American literature to depression with greater severity, more considerable guilt and loss of interest, typical vegetative symptoms such as decreased appetite and sleep, and other physical symptoms such as difficulty in concentrating, early morning awakening, and a diurnal mood swing (depression is worse in the morning). In DSM-IV, the 'melancholic features' specifier retains most of the features of endogenous depression; recent research suggests that 'lack of reactivity' and 'distinct quality of depressed mood' predict the full syndrome most consistently. However, melancholic depression can appear in response to an obvious precipitant. Endogenous depression has a better response to tricyclic antidepressants than does reactive depression and has a lower rate of response to psychotherapy and placebo.

Recent work has confirmed that the melancholic subtype of major depression is a more severe form of major depression that is associated with more depressive episodes, more symptoms, more impairment, more help-seeking, and more comorbidity with anxiety disorders and nicotine dependence but that is not qualitatively different from nonmelancholic major depression. Twin studies do not suggest an environmental influence on liability to melancholia in depressed patients. It is also now noted that melancholic and atypical depression are not necessarily mutually exclusive.[2]

3. Diagnosis and DSM-IV

The term 'affect' usually refers to the outward and changeable manifestation of a person's emotional tone, whereas 'mood' is a more enduring emotional orientation that colours the person's psychology. However, the change from 'affective disorders' in DSM-III to 'mood disorders' in DSM-IV does not imply a reconceptualization of what these disorders primarily involve (i.e., dysregulation of mood or dysregulation of affect); the two terms are used interchangeably in DSM-IV.

DSM-IV distinguishes between mood episodes and mood disorders. An episode is a period lasting at least 2 weeks during which there are enough symptoms for full criteria to be met for the disorder. Patients with or without a history of mania may have a major depressive episode if they fulfil these criteria, but 'major depressive disorder' (MDD) refers to one or more episodes of major depression in the absence of mania or hypomania (i.e., unipolar depression). A major depressive episode may be modified by additional specifiers for melancholic features and /or atypical features.

One needs to know several common terms used in the study of mood disorders. They are listed here below. In most treatment studies, 'response' is defined as at least 50% improvement, where 'partial response' is 25% improvement and 'nonresponse' is < 25% improvement. According to this terminology, patients who are still half as symptomatic as at the beginning of treatment will be considered responders at the end of a treatment study. Most studies consider improvement rather than remission as the end point. 'Remission' is defined as the state of having few or no symptoms of a mood disorder for at least 8 weeks. 'Recovery,' the period after remission, is present if no symptoms have been present for more than 8 weeks, and the term implies that the disorder is quiescent. A 'relapse' is a return of symptoms during the period of remission, and the term implies continuation of the original episode; whereas 'recurrence' is a later return of symptoms (during recovery), and this term implies development of a new episode. However, these distinctions can be difficult to make in clinical practice.[3]

4. Unipolar and bipolar Mood Disorders

One of the most important distinctions between mood disorders is the distinction between unipolar and bipolar categories. Unipolar mood disorders are characterized by depressive symptoms in the absence of a history of a pathologically elevated mood. In bipolar mood disorders, depression alternates or is mixed with mania or hypomania. Patients who have only had recurrent mania ('unipolar mania') are given the diagnosis of bipolar mood disorder on the assumption that they will eventually develop an episode of depression. Although most people think of elation as a defining characteristic of mania and hypomania, many patients

experience only irritability, anxiety, or a dysphoric sense of increased energy, as if they were 'crawling out of their skins.' In DSM-IV, it is noted that mania is a state of increased goal-directed behaviour that is pleasurable and has obvious potential for harm, whereas behaviour in mania is often excessive, disorganized, and dysphoric but not clearly harmful or dangerous. Most authorities agree that the bipolar-unipolar distinction is dichotomous: a patient either is manic, or is not manic.[4]

5. Clues to Bipolarity in Depressed Patients[5]

Clues to Bipolarity in Depressed Patients

1. highly recurrent depression
2. intense anger
3. racing thoughts
4. mood-incongruent psychotic symptoms
5. hallucinations
6. thrill seeking
7. increased libido with severe depression
8. family history of bipolar disorder
9. three consecutive generations with mood disorders

Since mania and depression are opposites, one would think that one of the two disorders could be present at a time. However, between 30% and 50% of manic episodes are accompanied by depressive symptoms. If the full criteria (except duration) are met for both mania and major depression, a mixed episode (dysphoric mania) should be diagnosed, according to DSM-IV.

6. Difference between Unipolar and Bipolar Depression[6]

Difference between Unipolar and Bipolar Depression

Unipolar	Bipolar
Later onset	Earlier onset
Fewer episodes	More episodes

Female>>male	Female=male
More psychomotor agitation	More psychomotor retardation and lethargy
Typical symptoms	Atypical symptoms
Insomnia	Hypersomnia
Lower risk of suicide	Greater risk of suicide
Less frequently accompanied by psychotic symptoms in younger patients	Greater likelihood of psychotic symptoms in younger patients
Antidepressants more effective	Antidepressants less effective
Lithium less effective	Lithium more effective
Family history of depression	Family history of mania and depression
Increase in free intracellular concentration of calcium irons is normal	Increase in free intracellular concentration of calcium irons is increased

7. Mood Disorders Tree[7]

Mood Disorders						
Mood disorder Due to medical Condition	Substance-Induced Mood disorder	Depressive Disorders (Unipolar Depression) (Unipolar – Depression alone)		Bipolar Disorders (Bipolar Depression) (Bipolar–Depression alternates or is mixed with mania or hypomania)		
		Major Depressive Disorder	Dysthymic Disorder	Bipolar I (One or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes)	Bipolar II (One or more Major Depressive episodes accompanied by at least one Hypomanic Episodes)	Cyclothymic Disorder (The hypomanic symptoms and the depressive symptoms are of insufficient number, severity, pervasiveness or duration to meet full criteria for Manic Episodes and a Major Depressive Episode respectively)

The mood disorder chapter includes disorders that have a disturbance in mood as the predominant feature. The chapter is divided into three parts.

The first part describes mood episodes (Major Depressive Episode, Manic Episode, Mixed Episode, and Hypomanic Episode). These episodes do not have their own diagnostic codes and cannot be diagnosed as separate entities; however, they serve as the building blocks for the disorder diagnoses.

The second part describes the Mood Disorders (e.g., Major Depressive Disorder, Dysthymic Disorder, Bipolar I Disorder). The criteria sets for most of the Mood Disorders require the presence or absence of the mood episodes described in the first part of the section.

The third part includes the specifiers that describe either the most recent mood episode or the course of recurrent episodes.

The fourth part deals with treatment especially various psychotherapies meant for the counsellors/psychotherapists.

The Mood Disorders are divided into Depressive Disorders ('unipolar depression'), the Bipolar Disorders, and two disorders based on aetiology – Mood Disorder Due to a General Medical Condition and Substance-Induced Mood Disorder.

The Depressive Disorders (i.e., Major Depressive Disorder, Dysthymic Disorder, and Depressive Disorder Not Otherwise Specified) are distinguished from the Bipolar Disorders by the fact

that there is no history of ever having had a Manic, Mixed, or Hypomanic Episode. The Bipolar Disorders (i.e., Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, and Bipolar Disorder Not Otherwise Specified) involve the presence (or history) of Manic Episodes, Mixed Episodes, or Hypomanic Episodes, usually accompanied by the presence (or history) of Major Depressive Episodes.

Major Depressive Disorder is characterized by one or more Major Depressive Episodes (i.e., at least 2 weeks of depressed mood or loss of interest accompanied by at least four additional symptoms of depression).

Dysthymic Disorder is characterized by at least 2 years of depressed mood for more days than not, accompanied by additional depressive symptoms that do not meet criteria for a Major Depressive Episode.

Depressive Disorder Not Otherwise Specified is included for coding disorders with depressive features that do not meet criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder With Depressed Mood, or Adjustment Disorder With Mixed Anxiety and Depressed Mood (or depressive symptoms about which there is inadequate or contradictory information).

Bipolar I disorder is characterized by one or more Manic or Mixed Episodes, usually accompanied by Major Depressive Episodes.

Bipolar II Disorder is characterized by one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode.

Cyclothymic Disorder is characterized by at least 2 years of numerous periods of hypomanic symptoms that do not meet criteria for a Manic Episode and numerous periods of depressive symptoms that do not meet criteria for a Major Depressive Episode.

Bipolar Disorder Not Otherwise Specified is included for coding disorders with bipolar features that do not meet criteria for any of the specific Bipolar Disorders defined in this section (or bipolar symptoms about which there is inadequate or contradictory information).

Mood Disorder Due to a General Medical Condition is characterized by a prominent and persistent disturbance in mood that is judged to be a direct physiological consequence of a general medical condition.

Substance-Induced Mood Disorder is characterized by a prominent and persistent disturbance in mood that is judge to be a direct physiological consequence of a drug of abuse, a medication, another somatic treatment for depression, or toxin exposure.

Mood Disorder Not Otherwise Specified is included for coding disorders with mood symptoms that do not meet the criteria for any specific Mood Disorder and in which it is difficult to choose between Depressive Disorder Not Otherwise Specified and Bipolar Disorder Not Otherwise Specified (e.g., acute agitation).

The specifiers described in the third part of the chapter are provided to increase diagnostic specificity, create more homogeneous subgroups, assist in treatment selection, and improve the prediction of prognosis. Some of the specifiers describe the current (or most recent) mood episode (i.e., Severity/Psychotic/Remission, Chronic, With Catatonic Features, With Melancholic Features, with Atypical Features, With Postpartum Onset). Other specifiers describe the course of recurrent mood episodes (i.e., Longitudinal Course Specifiers, With Seasonal Pattern, With Rapid Cycling).[8]

PART ONE

MOOD EPISODES

8. Mood Episodes

1) Major Depressive Episode

The essential feature of a Major Depressive Episode is a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional

symptoms drawn from a list that includes changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty in thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation, plans, or attempts. To count toward a Major Depressive Episode, a symptom must either be newly present or must have clearly worsened compared with the person's pre-episode status. The symptoms must persist for most of the day, nearly every day, for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning. For some individuals with milder episodes, functioning may appear to be normal, but requires markedly increased effort.[9]

Loss of interest or pleasure is nearly always present, at least to some degree. Individuals may report feeling less interested in hobbies, 'not caring anymore,' or not feeling any enjoyment in activities that were previously considered pleasurable. In some individuals, there is a significant reduction from previous levels of sexual interest or desire.

Appetite is usually reduced. Some may have increased appetite and may crave specific foods (e.g., sweets or other carbohydrates). When appetite changes are severe (in either direction), there may be a significant loss or gain in weight, or, in children, a failure to make expected weight gains.

The most common sleep disturbance is insomnia (initial insomnia – difficulty falling asleep, middle insomnia – waking up during the night and having difficulty returning to sleep, terminal insomnia – waking too early and being unable to return to sleep).

Psychomotor changes include agitation (e.g., the inability to sit still, pacing, hand-wringing; or pulling or rubbing of the skin, clothing, or other objects) or retardation (e.g., slowed speech, thinking, and body movements; increased pauses before answering; speech that is decreased in volume, inflection, amount, or variety of content, or muteness). The psychomotor agitation or retardation must be severe enough to be observable by others and not represent merely subjective feelings.

(1) Diagnostic Criteria[10]

Criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, it can be irritable mood.

(2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

(4) Insomnia or hypersomnia nearly every day

(5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) Fatigue or less of energy nearly every day.

(7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

(2) Associated Features and Disorders

Individuals with a Major Depressive Episode frequently present with tearfulness, irritability, brooding, obsessive rumination, anxiety, phobias, excessive worry over physical health, and complaints of pain. Some individuals may have Panic Attacks that occur in a pattern that meets criteria for Panic Disorder. In children, separation anxiety may occur. There may be difficulty in intimate relationships, and in sexual functioning (e.g., anorgasmia in women or erectile dysfunction in men).

(3) Course

A prodromal period that may include anxiety symptoms and mild depressive symptoms may last for weeks to months before the onset of a full Major Depressive Episode. The duration of a Major Depressive Episode is variable. An untreated episode typically lasts 6 months or longer, regardless of age at onset. In majority of cases, there is complete remission of symptoms, and functioning returns to the premorbid level. In a significant proportion of cases (perhaps 20%-30%), some depressive symptoms insufficient to meet full criteria for a Major Depressive Episode may persist for months to years and may be associated with some disability or distress.

(4) Differential Diagnosis[11]

In Common with	Characteristics Shared	Exclusively characteristic of Major Depressive Episode or of the disorder with which it is compared or difference between the two disorders

Mood Disorder Due to a General Medical Condition	Depression	In mood disorder due to a general medical condition – the mood disturbance is the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism)
Substance-Induced Mood Disorder	Depression	A substance (e.g., a drug of abuse, a medication, or a toxin) is etiologically related to the mood disturbance (e.g., depressed mood that occurs only in the context of withdrawal from cocaine)
Dementia	Declining cognitive function	In a dementia, there is usually a premorbid history of declining cognitive function, whereas the individual with a Major Depressive Episode is much more likely to have a relatively normal premorbid state and abrupt cognitive decline associated with the depression
Major Depressive Episodes With Irritable Mood or Mixed Episodes	Irritable mood	If criteria are met for both a Manic Episode and a Major Depressive Episode (except for the 2-week duration) nearly every day for at least a 1-week period, this would constitute a Mixed Episode
Attention-Deficit/ Hyperactivity Disorder	Distractibility and low frustration tolerance	If the criteria are met for both, Attention-Deficit/Hyperactivity Disorder may be diagnosed in addition to the Mood Disorder
Major Depressive Episode that occurs	Depression	In adjustment disorder the full criteria for a major depressive episode are not met.

in response to a psych-osocial stressor from Adjust-ment Disorder With Depressed Mood		
Bereavement	Depression	After the loss of a loved one, even if depressive symptoms are of sufficient duration and number to meet criteria for a Major Depressive Episode, it is Bereavement unless, they persist for more than 2 months or include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms or psychomotor retardation
Periods of sadness	Depression	Periods of sadness are inherent aspects of human experience unless criteria are met for severity (i.e., five out of nine symptoms), duration (i.e., most of the day, nearly every day for at least 2 weeks), and clinically significant distress or impairment.

2) Manic Episode

The elevated mood of a Manic Episode may be described as euphoric, unusually good, cheerful, or high; and is characterized by unceasing and indiscriminate enthusiasm for interpersonal, sexual, or occupational interactions. Although elevated mood is considered the prototypical symptom, the predominant mood disturbance may be irritability, particularly when the person's wishes are thwarted. Lability of mood (e.g., alternation between euphoria and irritability) is frequently seen. Inflated self-esteem is typically present, ranging from uncritical self-confidence to marked

grandiosity, and may reach delusional proportions. They may give advice on matters about which they have no special knowledge. Grandiose delusions are common. Almost invariably, there is a decreased need for sleep. When the sleep disturbance is severe, the person may go for days without sleep and yet not feel tired. Manic speech is typically pressured, loud, rapid, and difficult to interrupt and is characterized by joking, punning, and amusing irrelevancies. The individual may become theatrical, with dramatic mannerisms and singing. Sounds rather than meaningful conceptual relationships may govern word choice (i.e., clanging). If the mood is more irritable than expansive, speech may be marked by complaints, hostile comments, or angry tirades. The individual's thoughts may race, often at a rate faster than can be articulated. Distractibility is evidenced by an inability to screen out irrelevant external stimuli. The increase in goal-directed activity often involves excessive planning of, and excessive participation in, multiple activities (e.g., sexual, occupational, political, religious).

(1) Diagnostic Criteria

Criteria for Manic Episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalisation is necessary).

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The symptoms do not meet criteria for a Mixed Episode.

D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I disorder.

(2) Course

The mean age at onset for a first Manic Episode is the early 20s, but some cases start in adolescence and others start after age 50 years. Manic Episodes typically begin suddenly, with a rapid escalation of symptoms over a few days. Frequently it occurs following psychosocial stressors. The episodes usually last from a few weeks to several months and are briefer and end more abruptly than major Depressive Episodes. In many instances (50%-60%), a Major Depressive Episode immediately precedes or immediately follows a Manic Episode, with no intervening period of euthymia. If the Manic Episode occurs in the postpartum period, there may be an increased risk for recurrence in subsequent postpartum periods and the specifier 'With Postpartum Onset' is applicable.[12]

(3) Differential Diagnosis[13]

In Common with	Characteristics Shared	Exclusively characteristic of Manic Episode or of the disorder with which it is compared or difference between the two disorders
Mood Disorder Due to a General Medical Condition	Elevated mood	Unlike in Manic Episode, the mood disturbance is the consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumour, Cushing's syndrome)
Substance-Induced Mood Disorder	Elevated mood	Unlike in Manic Episode, a substance (e.g., a drug of abuse, a medication, or exposure to a toxin) is etiologically related to the mood disturbance
Hypomanic Episode	Share identical list of characteristics	Unlike in Manic Episode, the disturbance is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalisation
Major Depressive Episodes With Prominent Irritable Mood and Mixed Episodes	Irritability	If criteria are met for both a Manic Episode and a Major Depressive Episode nearly every day for at least a 1-week period, this would constitute a Mixed Episode

3) Mixed Episode

A mixed episode is characterized by a period of time (lasting at least 1 week) in which the criteria are met both for a Manic Episode and for a Major Depressive Episode nearly every day. The individual experiences rapidly alternating moods (sadness, irritability, euphoria) accompanied by symptoms of a Manic Episode and a Major Depressive Episode. The symptom presentation frequently includes agitation, insomnia, appetite dysregulation, psychotic features, and suicidal thinking. The disturbance must be sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalisation, or it is characterized by the presence of psychotic features. Mixed episodes appear to be more common in younger individuals and in individuals over age 60 years with Bipolar Disorder and may be more common in males than in females.

(1) Diagnostic Criteria[14]

Criteria for Mixed Episode

A. The criteria are met both for a Manic Episode and for a Major Depressive Episode (except for duration) nearly every day during at least a 1-week period.

B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar I Disorder.

(2) Differential Diagnosis[15]

In Common with	Characteristics Shared	Exclusively characteristic of Mixed Episode or of the disorder with which it is compared or difference between the two disorders
Mood Disorder Due to a General Medical Condition	Both Manic Episode and Major Depressive Episode	Unlike in Mixed Episode, the disturbance is the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumour, Cushing's syndrome)
Substance-Induced Mood Disorder	Both Manic Episode and Major Depressive Episode	Unlike in Mixed Episode, the disturbance is etiologically related to a substance (e.g., a drug of abuse, a medication, or exposure to a toxin)
Major Depressive Episodes with Prominent Irritable Mood and Manic Episodes With Prominent Irritable Mood	Both Manic Episode and Major Depressive Episode	They differ from Mixed Episode by duration
Attention-deficit/ Hyperactivity Disorder	Excessive activity, impulsive behaviour, poor judgement, and denial of problems	Unlike Mixed Episode, it has early onset, chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood or psychotic features

4) Hypomanic Episode

A Hypomanic Episode is defined as a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood that lasts at least 4 days.

(1) Diagnostic Criteria[16]

Criteria for Hypomanic Episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

(1) inflated self-esteem or grandiosity

(2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

(3) more talkative than usual or pressure to keep talking

(4) flight of ideas or subjective experience that thoughts are racing

(5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

(6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

(7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)

C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.

D. The disturbance in mood and the change in functioning are observable by others.

E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalisation, and there are no psychotic features.

F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light treatment) should not count toward a diagnosis of Bipolar II Disorder.

(2) Course

A Hypomanic Episode typically begins suddenly, with a rapid escalation of symptoms within a day or two. Episodes may last for several weeks to months and are usually more abrupt in onset and briefer than Major Depressive Episodes. In many cases, the Hypomanic Episode may be preceded or followed by a Major Depressive Episode. Studies indicate that 5%-15% of individuals with hypomania will ultimately develop a Manic Episode.

(3) Differential Diagnosis[17]

In Common with	Characteristics Shared	Exclusively characteristic of Hypomanic Episode or of the disorder with which it is compared or difference between the two disorders
Mood Disorder Due to a General Medical Condition	Elevated, expansive, or irritable mood	Unlike in Hypomanic Episode, the disturbance is the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, brain tumour, Cushing's syndrome)
Substance-Induced Mood Disorder	Elevated, expansive, or irritable mood	Unlike in Mixed Episode, the disturbance is etiologically related to a substance (e.g., a drug of abuse, a medication, or exposure to a toxin)

Manic Episode	Identical list of characteristic symptoms	The disturbance in Hypomanic Episode is not sufficiently severe to cause marked impairment in social or occupational functioning or to require hospitalisation
Attention-deficit/ Hyperactivity Disorder	Excessive activity, impulsive behaviour, poor judgement, and denial of problems	Unlike Hypomanic Episode, it has early onset (i.e., before age 7 years), chronic rather than episodic course, lack of relatively clear onsets and offsets, and the absence of abnormally expansive or elevated mood

PART TWO

MOOD DISORDERS

SECTION - I

9. Depressive Disorders

1) Differential Diagnosis of Depressive Disorder[18]

<table>
<tr><td colspan="4">Differential Diagnosis of Depressive Disorder</td></tr>
<tr><td colspan="4">Patient presents with chief complaint of depression</td></tr>
<tr><td colspan="4">Does patient have a history of mania or hypomania?</td></tr>
<tr><td>If Yes, Consider Bipolar Disorder</td><td colspan="3">If No, Is there a medical condition or substance that causes the mood disorder?</td></tr>
<tr><td></td><td>If Yes, Mood Disorder due to a general medical condition</td><td>If Yes, Substance-induced mood disorder</td><td>If No, Has patient had at least five of nine classic symptoms, including either mood or loss of interest or pleasure?</td></tr>
</table>

			If No, Depressive disorder NOS or dysthymic disorder		If Yes, Has patient had symptoms for at least 2 weeks?		
			Has patient had at least three of nine symptoms of dysthymia for at least 2 years?		If No, Has patient had at least three of nine symptoms of dysthymia for at least 2 years		If Yes, Major depressive disorder
			If No, Depressive disorder NOS	If Yes, Dysthymic disorder	If No, Depressive disorder NOS	If Yes, Dysthymic disorder	

2) Major Depressive Disorder

(1) Diagnostic Features

The essential feature of Major Depressive Disorder is a clinical course that is characterized by one or more Major Depressive Episodes without a history of Manic, Mixed, or Hypomanic Episodes.

The fourth digit in the diagnostic code (DSM-IV) for Major Depressive Disorder indicates whether it is a single Episode (used only for first episodes) or Recurrent. An episode is considered to have ended when the full criteria for the Major Depressive Episode have not been met for at least 2 consecutive months. During this 2-month period, there is either complete resolution of symptoms or the presence of depressive symptoms that no longer meet the full criteria for a Major Depressive Episode (In Partial Remission). The fifth digit in the diagnostic code for Major Depressive Disorder indicates the current state of the disturbance. If the criteria for a Major Depressive Episode are met, the severity of the episode is noted as Mild, Moderate, Severe Without Psychotic Features, or Severe with Psychotic features. If the criteria for a Major

Depressive Episode are not currently met, the fifth digit is used to indicate whether the disorder is In Partial Remission or In full Remission.[19]

(2) Specifiers

The following specifiers may be used to describe the current Major Depressive Episode (or, if criteria are not currently met for a Major Depressive Episode, the most recent Major Depressive Episode):

Mild, Moderate, Severe Without Psychotic Features, Severe with Psychotic Features, In Partial Remission, In Full Remission, Chronic, with Catatonic Features, with Melancholic Features, with Atypical Features, With Postpartum Onset.

The following specifiers may be used to indicate the pattern of the episodes and the presence of interepisode symptomatology for Major Depressive Disorder, Recurrent:

Longitudinal Course Specifiers (With or Without Full Interepisode Recovery),

With Seasonal Pattern

(3) Recording Procedures

The diagnostic codes for Major Depressive Disorder are selected as follows:

1. The first three digits are 296.
2. The fourth digit is either 2 (if there is only a single Major Depressive Episode) or 3 (if there are recurrent Major Depressive Episodes).
3. The fifth digit indicates the following: 1 for Mild severity, 2. for Moderate severity, 3 for Severe Without Psychotic Features, 4 for Severe With Psychotic Features, 5 for In Partial Remission, 6 for In full Remission, and 0 if Unspecified. Other specifiers for Major Depressive Disorder cannot be coded.

In recording the name of a diagnosis, terms should be listed in the following order. Major Depressive Disorder, specifiers coded in the fourth digit (e.g., Recurrent), specifiers coded in the fifth digit (e.g., Mild, Severe With Psychotic Features, In Partial remission), as many specifiers (without codes) as apply to the most

recent episode (e.g., With Melancholic Features, With Postpartum Onset), and as many specifiers (without codes) as apply to the course of episodes (e.g., With Full Interepisode Recovery). Take for example 296.32, which means: Major Depressive Disorder, Recurrent, Moderate, With Atypical Features, With Seasonal Pattern, With Full Interepisode Recovery.[20]

(4) Major Depressive Disorder, Single Episode[21]

Diagnostic Criteria for Major Depressive Disorder, Single Episode

(DSM-IV Code: 296.2x & ICD-10 Code: F32.x)

A. Presence of a single Major Depressive Episode.

B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise specified.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Specify (for current or most recent episode):

Severity/Psychotic/Remission Specifiers

Chronic

With Catatonic Features or With Melancholic Features or With Atypical Features or With Postpartum Onset

(5) Major Depressive Disorder Recurrent[22]

Diagnostic Criteria for Major Depressive Disorder Recurrent
(DSM-IV Code: 296.3x & ICD-10 Code: F33.x)

A. Presence of two or more Major Depressive Episodes.

Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.

B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise specified.

C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode. Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

Specify (for current or most recent episode):

Severity/Psychotic/Remission Specifiers

Chronic

With Catatonic Features or With Melancholic Features or With Atypical Features or With Postpartum Onset

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) or With Seasonal Pattern

a. Associated Descriptive Features and Mental Disorders

Major Depressive Disorder is associated with high mortality. Up to 15% of individuals with severe Major Depressive Disorder die by suicide. Epidemiological evidence also suggests that there is fourfold increase in death rates in individuals with Major Depressive Disorder who are over age 55 years. Among the individuals seen in general medical settings with this disorder, they may have a markedly increased likelihood of death in the first year. These patients have more pain and physical illnesses and decreased physical, social, and role functioning.[23]

b. Course

Major Depressive Disorder may begin at any age, with an average age at onset in the mid-20s. The course of Major Depressive Disorder, Recurrent, is variable. Some people have isolated episodes that are separated by many years without any depressive symptoms, whereas others have clusters of episodes, and still others have increasingly frequent episodes as they grow older. Approximately 50%-60% of individuals with Major Depressive Disorder, Single Episode, can be expected to have a second episode. Individuals who have had two episodes have a 70% chance of having a third, and individuals who have had three episodes have a 90% chance of having a fourth. About 5%-10% of individuals with major Depressive Disorder, Single Episode, subsequently

develop a Manic Episode (i.e., develop Bipolar I Disorder). Major Depressive Episodes may end completely (in about two-thirds of cases), or only partially or not at all (in about one-third of cases).

c. Differential Diagnosis[24]

In Common with	Characteristics Shared	Exclusively characteristic of Major Depressive Disorder or of the disorder with which it is compared, or the difference between the two disorders
Mood Disorder Due to a General Medical Condition	Mood disturbance	Unlike in Major Depressive Disorder, the disturbance is the direct physiological consequence of a specific general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism)
Substance-Induced Mood Disorder	Mood disturbance	Unlike in Major Depressive Disorder, the disturbance is etiologically related to a substance (e.g., a drug of abuse, a medication, or exposure to a toxin)
Dysthymic Disorder	Mood disturbance	In Major Depressive Disorder, the depressed mood must be present for most of the day, nearly every day, for a period of at least 2 weeks. In Dysthymic Disorder the depressed mood must be present for more days than not, over a period of at least 2 years.

3) Dysthymic Disorder

(DSM-IV Code: 300.4 & ICD-10 Code: F34.1)

The essential feature of Dysthymic Disorder is a chronically depressed mood that occurs for most of the day more days than not for at least 2 years. Patients usually describe their mood as sad or 'down in the dumps.' The diagnosis of Dysthymic Disorder can be made only if the initial 2-year period of dysthymic symptoms is free of Major Depressive Episodes. The most commonly encountered symptoms in Dysthymic Disorder may be feelings of inadequacy; generalized loss of interest or pleasure; social withdrawal; feelings of guilt or brooding about the past; subjective feelings of irritability or excessive anger; and decreased activity, effectiveness, or productivity. In children, Dysthymic Disorder seems to occur equally in both sexes and often results in impaired school performance and social interaction. Children and adolescents with Dysthymic Disorder are usually irritable and cranky as well as depressed. They have low self-esteem and poor social skills and are pessimistic. In adulthood, women are two to three times more likely to develop Dysthymic Disorder than are men.

(1) Diagnostic Criteria

Diagnostic Criteria for Dysthymic Disorder

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. Note: In children and adolescents, mood can be irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

(1) Poor appetite or overeating

(2) insomnia or hypersomnia

(3) low energy or fatigue

(4) low self-esteem

(5) poor concentration or difficulty making decisions

(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.

Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Early Onset: if onset is before age 21 years

Late Onset: if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

With Atypical Features

(2) Course

This disorder often has an early and insidious onset (i.e., in childhood, adolescence, or early adult life) as well as a chronic course. In clinical settings, individuals with Dysthymic Disorder usually have superimposed Major Depressive Disorder. If Dysthymic Disorder precedes the onset of Major Depressive Disorder, there is less likelihood that there will be spontaneous full interepisode recovery between Major Depressive Episodes and a greater likelihood of having more frequent subsequent episodes.[25]

(3) Differential Diagnosis[26]

In Common with	Characteristics Shared	Exclusively characteristic of Dysthymic Disorder or of the disorder with which it is compared, or the difference between the two dis orders
Mood Disorder Due to a General Medical Condition	Mood disturbance	Unlike in Dysthymic Disorder, disturbance is the direct physiological consequence of a specific, usually chronic, general medical condition (e.g., multiple sclerosis)

Substance-Induced Mood Disorder	Mood disturbance	Unlike in Dysthymic Disorder, the disturbance is etiologically related to a substance (e.g., a drug of abuse, a medication, or exposure to a toxin)
Major Depressive Disorder	Similar symptoms	In Major Depressive Disorder, the depressed mood must be present for most of the day, nearly every day, for a period of at least 2 weeks. In Dysthymic Disorder the depressed mood must be present for more days than not over a period of at least 2 years.

4) Depressive Disorder Not Otherwise Specified

(DSM-IV Code: 311 & ICD-10 Code: F32.9)

The Depressive Disorder Not Otherwise Specified category includes disorders with depressive features that do not meet the criteria for Major Depressive Disorder, Dysthymic Disorder, Adjustment Disorder with Depressed Mood, or Adjustment Disorder with Mixed Anxiety and Depressed Mood. Sometimes depressive symptoms can present as part of an Anxiety Disorder Not Otherwise Specified. Examples of Depressive Disorder Not Otherwise Specified include

1. Premenstrual Dysphoric Disorder: in most menstrual cycles during the past year, symptoms (e.g., markedly depressed mood, marked anxiety, marked affective lability, decreased interest in activities) regularly occurred during the last week of the luteal phase (and remitted within a few days of the onset of menses). These symptoms must be severe enough to markedly interfere with work, school, or usual activities and be entirely absent for at least 1 week postmenses.
2. Minor Depressive Disorder: episodes of at least 2 weeks of depressive symptoms but with fewer than the five items required for Major Depressive Disorder.
3. Recurrent Brief Depressive Disorder: depressive episodes lasting from 2 days up to 2 weeks, occurring at least once a month for 12 months (not associated with the menstrual cycle)

4. Postpsychotic Depressive Disorder of Schizophrenia: a Major Depressive Episode that occurs during the residual phase of Schizophrenia.
5. A major Depressive Episode superimposed on Delusional Disorder, Psychotic Disorder Not Otherwise Specified, or the active phase of Schizophrenia.
6. Situations in which the clinician has concluded that a depressive disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced.[27]

SECTION - II

10. Bipolar Disorders

1) Differential Diagnosis of Bipolar Disorder[28]

<table>
<tr><td colspan="6">Differential Diagnosis of Bipolar Disorders</td></tr>
<tr><td colspan="6">Patient presents with chief complaint of depression</td></tr>
<tr><td colspan="6">Has patient had an elevated, expansive or irritable mood with decreased need for sleep, increased activity, and impaired functioning for at least 1 week or needed hospitalisation?</td></tr>
<tr><td colspan="3">If No, Has patient had a milder or briefer period of elevated mood?</td><td colspan="3">If Yes, Does patient have a medical condition or has patient used a drug that could account for the elevated mood?</td></tr>
<tr><td>If No, Consider major depression dysthymic disorder, or other unspecified depressive disorder</td><td colspan="2">If Yes, Has patient qualified for major depressive disorder?</td><td>If Yes Mood disorder due to a general medical condition</td><td>If Yes, substance-induced mood disorder</td><td>If uncertain, Bipolar disorder NOS</td><td>If No, Has antidepresant treatment precipitated the manic episode?</td></tr>
<tr><td></td><td>If Yes, Bipolar II disorder</td><td>If No, Has patient had a number of periods of milder elevations and depressions of mood for at least 2 years?</td><td></td><td></td><td></td><td>If No, Bipolar I Disorder</td><td>If Yes, and if this is only evidence of mania do not code for bipolar disorder</td></tr>
<tr><td></td><td></td><td>IF Yes, Cyclothymic disorder</td><td>If No Bipolar Disorder NOS</td><td></td><td></td><td></td><td></td></tr>
</table>

This section includes Bipolar I Disorder, Bipolar II Disorder, Cyclothymia, and Bipolar Disorder Not Otherwise Specified.

There are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, and Most Recent Episode Unspecified.

Bipolar I Disorder, Single Manic Episode, is used to describe individuals who are having a first episode of mania. The remaining criteria sets are used to specify the nature of the current (or most recent) episode in individuals who have had recurrent mood episodes.

2) Bipolar I Disorder

(1) Diagnostic Criteria

The essential feature of Bipolar I is a clinical course that is characterized by the occurrence of one or more Manic Episodes

or Mixed Episodes. Often the individuals have also had one or more Major Depressive Episodes.

Diagnostic Criteria for Bipolar I Disorder
Single Manic Episode

(DSM-IV Code: 296.0x & ICD-10 Code: F30.x)

A. Presence of only one Manic Episode and no past Major Depressive Episodes.

Note: Recurrence is defined as either a change in polarity from depression or an interval of at least 2 months without manic symptoms.

B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify if:

Mixed: if symptoms meet criteria for a Mixed Episode

Specify (for current or most recent episode):

Severity/Psychotic/Remission Specifiers

With Catatonic Features or With Postpartum Onset

(2) Recording Procedures

The diagnostic codes for Bipolar I Disorder are selected as follows:

1. The first three digits are 296.
2. The fourth digit is 0 if there is a single Manic Episode. For recurrent episodes, the fourth digit is 4 if the current or most recent episode is a Hypomanic Episode or a Manic Episode, 5 if it is a Major Depressive Episode, 6 if it is a Mixed Episode and 7 if the current or most recent episode is Unspecified.
3. The fifth digit (except for bipolar I Disorder, Most Recent Episode Hypomanic, and Bipolar I Disorder, Most Recent Episode Unspecified) indicates the following: 1 – Mild severity, 2 – Moderate severity, 3 – Severe without Psychotic Features, 4 – Severe With Psychotic Features, 5 – In Partial Remission, 6 – In Full Remission, and 0 – Unspecified.

(3) Course

Bipolar I Disorder is a recurrent disorder – more than 90% of individuals who have a single Manic Episode go on to have future episodes. Roughly 60%-70% of Manic Episodes occur immediately before or after a Major Depressive Episode. The interval between episodes tends to decrease as the individual ages. Although the majority of individuals with Bipolar I Disorder return to a fully functional level between episodes, some (20%-30%) continue to display mood lability and interpersonal or occupational difficulties.[29]

(4) Bipolar I Disorder Most Recent Episode Hypomanic[30]

Diagnostic Criteria for Bipolar I Disorder
Most Recent Episode Hypomanic
(DSM-IV Code: 296.40 & ICD-10 Code: F31.0)

A. Currently (or most recently) in a Hypomanic Episode.

B. There has previously been at least one Manic Episode or Mixed Episode.

C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The mood episodes in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify:

Longitudinal Course Specifiers (With and Without Inerepisode Recovery) or With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) or With Rapid Cycling

(5) Bipolar I Disorder Most Recent Episode Manic[31]

Diagnostic Criteria for Bipolar I Disorder,
Most Recent Episode Manic
(DSM-IV Code: 296.4x & ICD-10 Code: F31.x)

A. Currently (or most recently) in a Manic Episode.

B. There has previously been at least one Major Depressive Episode, Manic Episode, or Mixed Episode.

C. The mood episodes in Criteria A and B are not better accounted for by Schizoafective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify (for current or most recent episode):

Severity/Psychotic/Remission Specifiers

With Catatonic Features or With Postpartum Onset

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) or With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) or With Rapid Cycling

(6) Bipolar I Disorder Most Recent Episode Mixed[32]

Diagnostic Criteria for Bipolar I Disorder, Most Recent Episode Mixed

(DSM-IV Code: 296.6x & ICD-10 Code: F31.6)

A. Currently (or most recently) in a Mixed Episode.

B. There has previously been at least one Major Depressive Episode, Manic Episode, or Mixed Episode.

C. The mood episodes in Criteria A and B are not better accounted for by Schizoafective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify (for current or most recent episode):

Severity/Psychotic/Remission Specifiers

With Catatonic Features or With Postpartum Onset

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) or With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) or With Rapid Cycling

(7) Bipolar I Disorder Most Recent Episode Depressed[33]

Diagnostic Criteria for Bipolar I Disorder, Most Recent Episode Depressed

(DSM-IV Code: 296.5x & ICD-10 Code: F31.x)

A. Currently (or most recently) in a Major Depressive Episode.

B. There has previously been at least one Manic Episode or Mixed Episode.

C. The mood episodes in Criteria A and B are not better accounted for by Schizoafective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Specify (for current or most recent episode):

Severity/Psychotic/Remission Specifiers

Chronic

With Catatonic Features or With Melancholic Features or With Atypical Features or With Postpartum Onset

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) or With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) or With Rapid Cycling

(8) Bipolar I Disorder Most Recent Episode Unspecified[34]

Diagnostic Criteria for Bipolar I Disorder, Most Recent Episode Unspecified

(DSM-IV Code: 296.7 & ICD-10 Code: F31.9)

A. Criteria, except for duration, are currently (or most recently) met for a Manic, a Hypomanic, a Mixed, or a Major Depressive Episode.

B. There has previously been at least one Manic Episode or Mixed Episode.

C. The mood symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on

Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

E. The mood symptoms in Criteria A and B are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) or With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) or With Rapid Cycling

3) Bipolar II Disorder (Recurrent Major Depressive Episodes with Hypomanic Episodes)

(DSM-IV Code: 296.89 & ICD-10 Code: F31.8)

The essential feature of Bipolar II Disorder is a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. The presence of a Manic or Mixed Episode precludes the diagnosis of Bipolar II Disorder. Patients with Bipolar II disorder may not view the Hypomanic Episodes as pathological, although others may be troubled by the patient's erratic behaviour. Often patients, particularly when in the midst of a Major Depressive Episode, do not recall periods of hypomania without reminders from close friends or relatives. Information from other informants is often critical in establishing the diagnosis of Bipolar II Disorder.

(1) Diagnostic Criteria

Diagnostic Criteria for Bipolar II Disorder

A. Presence (or history) of one or more Major Depressive Episodes.

B. Presence (or history) of at least one Hypomanic Episode.

C. There has never been a Manic Episode or a Mixed Episode.

D. The mood symptoms in Criteria A and B are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

E. The Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify current or most recent episode:

Hypomanic. This specifier is used if the current (or most recent) episode is a Hypomanic Episode.

Depressed. This specifier is used if the current (or most recent) episode is a Major Depressive Episode.

The following specifiers may be used to describe the current Major Depressive Episode in Bipolar II Disorder (or the most recent Major Depressive Episode if currently in remission only if it is the most recent type of mood episode):

Mild, Moderate, Severe Without Psychotic Features, Severe With Psychotic Features, In Partial Remission, In Full Remission

Chronic

With Catatonic Features or With Melancholic Features or With Atypical Features or With Postpartum Onset

The following specifiers may be used to indicate the pattern or frequency of episodes:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) or With Seasonal Pattern (applies only to the pattern of Major Depressive Episodes) or With Rapid Cycling

(2) Recording Procedures

The diagnostic code for Bipolar II Disorder is 296.89; none of the specifiers are codable. In recording the name of the diagnosis, terms should be listed in the following order: Bipolar II Disorder, specifiers indicating current or most recent Major Depressive Episode (e.g., Moderate, With Melancholic Features, With Postpartum Onset), and as many specifiers as apply to the course of episodes (e.g., With Seasonal Pattern); for example, 296.89 Bipolar II Disorder, Depressed, Severe With Psychotic Features, With Melancholic Features, With seasonal Pattern.

(3) Course

Bipolar II Disorder may be more common in women than in men. A lifetime prevalence of Bipolar II Disorder is approximately 0.5%. Roughly 60%-70% of the Hypomanic Episodes in Bipolar II Disorder occur immediately before or after a Major Depressive Episode. The interval between episodes tends to decrease as the individual ages. Approximately 5%-15% of individuals with Bipo-

lar II Disorder have multiple (four or more) mood episodes (Hypomanic or Major Depressive) that occur within a given year. If this pattern is present, it is noted by the specifier With Rapid Cycling. The rapid-cycling pattern is associated with a poorer prognosis. Although the majority of the patients return to a fully functional level between episodes, approximately 15% continue to display mood lability and interpersonal or occupational difficulties. Psychotic symptoms do not occur in Hypomanic Episodes, and they appear to be less frequent in the Major Depressive Episodes in Bipolar II Disorder than is the case for bipolar I Disorder.[35]

(4) Differential Diagnosis[36]

In Common with	Characteristics Shared	Exclusively characteristic of Bipolar II Disorder or of the disorder with which it is compared, or difference between the two disorders
Mood Disorder Due to a General Medical Condition	Mood disturbance	Unlike in Bipolar II Disorder, the disturbance is the direct physiological consequence of a specific, usually chronic, general medical condition (e.g., multiple sclerosis, stroke, hypothyroidism)
Substance-Induced Mood Disorder	Mood disturbance	Unlike in Bipolar II disorder, the disturbance is etiologically related to a substance (e.g., a drug of abuse, a medication, or exposure to a toxin)
Major Depressive Disorder	Mood Disturbance	Unlike Major Depressive Disorder, it has a lifetime history of at least one Hypomanic Episode
Dysthymic Disorder	Mood Disturbance	Unlike Dysthymic Disorder, it has a lifetime history of at least one Hypomanic Episode
Bipolar I Disorder	Mood Disturbance	Unlike Bipolar II, Bipolar I has the presence of one or more Manic or Mixed Episodes
Cyclothymic Disorder	Mood disturbance	Unlike Cyclothymic disorder, it has the presence of one or more Major Depressive Episodes

4) Cyclothymic Disorder

(DSM-IV Code: 301.13 & ICD-10 Code: F34.0)

The essential feature of Cyclothymic Disorder is a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms. The hypomanic symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a Manic Episode, and the depressive symptoms are of insufficient number, severity, pervasiveness, or duration to meet full criteria for a Major Depressive Episode. The diagnosis of Cyclothymic Disorder is made only if the initial 2-year period of Cyclothymic symptoms is free of Major Depressive, Manic, and Mixed Episodes.

(1) Diagnostic Criteria

Diagnostic Criteria for Cyclothymic Disorder

A. For at least 2 years, the presence of numerous periods with hypomanic symptoms and numerous periods with depressive symptoms that do not meet criteria for a Major Depressive Episode. Note: In children and adolescents, the duration must be at least 1 year.

B. During the above 2-year period (1 year in children and adolescents), the person has not been without the symptoms in Criterion A for more than 2 months at a time.

C. No Major Depressive Episode, Manic Episode, or Mixed Episode has been present during the first 2 years of the disturbance.
Note: After the initial 2 years (1 year in children and adolescents) of Cyclothymic Disorder, there may be superimposed Manic or Mixed Episodes (in which case both Bipolar I Disorder and Cyclothymic Disorder may be diagnosed) or Major Depressive Episodes (in which case both Bipolar II disorder and Cyclothymic Disorder may be diagnosed).

D. The symptoms in Criteria A are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

F. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

(2) Course

Cyclothymic Disorder often begins early in life and is sometimes considered to reflect a temperamental predisposition to other Mood Disorders (especially Bipolar Disorders). This disorder usually begins in adolescence or early adult life. Onset late in adult life may suggest a Mood Disorder Due to a General Medical Condition such as multiple sclerosis. It usually has an insidious onset and a chronic course. There is a 15%-50% risk that the person will subsequently develop Bipolar I or II Disorder.[37]

(3) Differential Diagnosis[38]

In Common with	Characteristic Shared	Exclusively characteristic of Cyclothymic Disorder or of the disorder with which it is compared, or difference between the two disorders
Mood Disorder Due to a General Medical Condition	Mood disturbance	Unlike in Cyclothymic Disorder, the disturbance is the direct physiological consequence of a specific, usually chronic, general medical condition (e.g., hypothyroidism)
Substance-Induced Mood Disorder	Mood disturbance	Unlike in Cyclothymic Disorder, the disturbance is etiologically related to a substance (especially stimulants)
Bipolar I Disorder, With Rapid Cycling and Bipolar II Disorder, With Rapid Cycling.	Frequent marked shifts in mood	The Cyclothymic Disorder need not meet the full criteria for Major Depressive, Manic, Or Mixed Episode whereas the two types being compared with require the meeting of the full criteria.
Borderline Personality Disorder	Marked shifts in mood	If the criteria are met for each disorder, both Borderline Personality Disorder and Cyclothymic Disorder may be diagnosed

5) Bipolar Disorder Not Otherwise Specified

(DSM-IV Code: 296.80 & ICD-10 Code: F31.9)

The Bipolar Disorder Not Otherwise Specified category includes disorders with bipolar features that do not meet criteria for any specific Bipolar Disorder. Examples include the following:[39]

1. Very rapid alternation (over days) between manic symptoms and depressive symptoms that do not meet minimal duration criteria for a Manic Episode or a Major Depressive Episode
2. Recurrent Hypomanic Episodes without intercurrent depressive symptoms
3. A Manic or Mixed Episode superimposed on Delusional Disorder, residual Schizophrenia, or Psychotic Disorder Not Otherwise Specified
4. Situations in which the clinician has concluded that a Bipolar Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

SECTION - III

OTHER MOOD DISORDERS

11. Mood Disorder due to a General Medical Condition

(DSM-IV Code: 293.83 & ICD-10 Code: F06.xx)

The essential feature of Mood Disorder Due to a General Medical Condition is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition. The mood disturbance may involve depressed mood; markedly diminished interest or pleasure; or elevated, expansive, or irritable mood. Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met; the predominant symptoms type may be indicated by using one of the following subtypes: With Depressive Features, With Major Depressive-Like Episode, With Manic Features, or With Mixed Features.

1) Diagnostic Criteria

Diagnostic Criteria for Mood Disorder Due to a General Medical Condition

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:

(1) depressed mood or markedly diminished interest or pleasure in all, or almost all, activities

(2) elevated, expansive, or irritable mood

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition.

C. The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Depressed Mood in response to the stress of having a general medical condition).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify type:

With Depressive Features: if the predominant mood is depressed but the full criteria are not met for a Major Depressive Episode

With Major Depressive-Like Episode: if the full criteria are met (except Criteria D) for a Major Depressive Episode

With Manic Features: if the predominant mood is elevated, euphoric, or irritable

With Mixed Features: if the symptoms of both mania and depression are present but neither predominates

Coding note: Include the name of the general medical condition on Axis I, e.g., 293.83 Mood Disorder Due to Hypothyroidism, With Depressive Features; also code the general medical condition on Axis III.

Coding note: If depressive symptoms occur as part of a preexisting dementia, indicate the depressive symptoms by coding the appropriate subtype of the dementia if one is available, e.g., 290.21 Dementia of the Alzheimer's Type, With Late Onset, With Depressed Mood.

2) Prevalence

Prevalence estimates for Mood Disorder Due to a General Medical condition are confirmed to those presentations with depressive features. It has been observed that 25%-40% of individuals with certain neurological condition (including Parkinson's disease, Huntington's disease, multiple sclerosis, stroke, and Alzheimer's disease) will develop a marked depressive disturbance at some point during the course of illness. For general medical conditions without direct central nervous system involvement, rates are far more variable, ranging from more than 60% in Cushing's syndrome to less than 8% in end-stage renal disease.[40]

3) Differential Diagnosis[41]

In Common with	Characteristics Shared	Exclusively characteristic of Mood Disorder Due to a General Medical Condition or of the disorder with which it is compared, or difference between the two disorders
Substance-Induced Mood Disorder	Mood disturbance	Unlike in Mood Disorder Due to a General Medical Condition, symptoms occur during or shortly after (i.e., within 4 weeks of) Substance Intoxication or Withdrawal. Medication use may be specially indicative of Substance-Induced Disorder, depending on the character, duration, or amount of the substance used
Major Depressive Disorder, Bipolar I Disorder, Bipolar II Disorder, and Adjustment Disorder With Depressed Mood (e.g., a maladaptive response to the stress of having a general medical condition)	Mood disturbance	Unlike in Mood Disorder Due to a General Medical Condition, there is no specific and direct causative physiological mechanisms associated with a general medical condition

4) Some Medical Conditions that can cause Manic or Depressive Syndromes[42]

Some Medical Conditions that can cause Manic or Depressive Syndromes

Neurological diseases: Parkinson's disease, Huntington's disease, traumatic brain injury, stroke, dementias, multiple sclerosis

Metabolic disease: Electrolyte disturbances, renal failure, vitamin deficiencies or excess, acute intermittent porphyria, Wilson's disease, environmental toxins, heavy metals

Gastrointestinal disease: Irritable bowel syndrome, chronic pancreatitis, Crohn's disease, cirrhosis, hepatic encephalopathy

Endocrine disorders: Hypo- and hyperthyroidism, Cushing's disease, Addison's disease, diabetes mellitus, parathyroid dysfunction

Cardiovascular disease: Myocardial infarction, angina, coronary artery bypass surgery, cardiomyopathies

Pulmonary disease: Chronic obstructive pulmonary disease, sleep apnea, reactive airway disease

Malignancies and hematologic disease: Pancreatic carcinoma, brain tumours, paraneoplastic effects of lung cancers, anemias

Autoimmune disease: Systemic lupus erythematosis, fibromyalgia, rheumatoid arthritis

12. Substance-Induced Mood Disorder

The essential feature of Substance-Induced Mood Disorder is a prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, other somatic treatment for depression, or toxin exposure. Depending on the nature of the substance and the context in which the symptoms occur (i.e., during intoxication or withdrawal), the disturbance may involve depressed mood or markedly diminished interest or pleasure or elevated, expansive, or irritable mood. Although the clinical presentation of the mood disturbance may resemble that of a Major Depressive, Manic, Mixed, or Hypomanic Episode, the full criteria for one of these episodes need not be met.

1) Diagnostic Criteria[43]

Diagnostic Criteria for Substance-induced Mood Disorder

A. A prominent and persistent disturbance in mood predominates in the clinical picture and is characterized by either (or both) of the following:
   (1) depressed mood or markedly diminished interest or pleasure in all or almost all, activities
   (2) elevated, expansive, or irritable mood

B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):
   (1) the symptoms in Criteria A developed during, or within a month of, Substance Intoxication or Withdrawal
   (2) medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by a Mood Disorder that is not substance induced. Evidence that the symptoms are better accounted for by a Mood Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use, or there is other evidence that suggests the existence of an independent non-substance-induced Mood Disorder (e.g., a history of recurrent Major Depressive Episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

E. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the mood symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the symptoms are sufficiently severe to warrant independent clinical attention.

Code (Specific Substance)-Induced Mood Disorder:

(291.8 Alcohol; 292.84 Amphetamine (or Amphetamine-Like substance); 292.84 Cocaine; 292.84 Hallucinogen; 292.84 Opioid; 292.84 Phencyclidine (or Phencyclidine-Like Substance); 292.84 Sedative, Hypnotic, or Anxiolytic; 292.84 Other (or Unknown Substance)

Specify type:

With Depressive Features: if the predominant mood is depressed

With Manic Features: if the predominant mood is elevated, euphoric, or irritable

With Mixed Features: if symptoms of both mania and depression are present and neither predominates

Specify if:

With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome

With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

2) Differential Diagnosis[44]

In Common with	Characteristics Shared	Exclusively characteristic of Substance-Induced Mood Disorder or of the disorder with which it is compared, or the difference between the two disorders
Substance Intoxication & Substance Withdrawal	Mood symptoms	Unlike in Substance Intoxication and Substance Withdrawal, the mood symptoms in Substance-Induced Mood Disorder are judged to be in excess of those usually associated with Intoxication or Withdrawal syndrome and the symptoms are sufficiently severe to warrant independent clinical attention.
Delirium	Mood symptoms	In Delirium, the mood symptoms occur exclusively during its course
Primary Mood Disorder	Mood symptoms	Unlike in Primary Mood Disorder, the symptoms are etiologically related to intoxication or withdrawal of a substance

13. Mood Disorder Not Otherwise Specified[45]

(DSM-IV Code: 296.90 & ICD-10 Code: F39)

This category includes disorders with mood symptoms that do not meet the criteria for any specific Mood Disorder and in which it is difficult to choose between Depressive Disorder Not Otherwise Specified and Bipolar Disorder Not Otherwise Specified (e.g., acute agitation).

PART THREE

SPECIFIERS

SECTION - 1

Specifiers Describing the Most Recent Episode

14. Specifiers Describing the Most Recent Episode

A number of specifiers for Mood Disorders are provided to increase diagnostic specificity and create more homogeneous subgroups, assist in treatment selection, and improve the prediction of prognosis.

1) Episode Specifiers that apply to Mood Disorders[46]

Episode Specifiers that apply to Mood Disorders						
Mood Disorders	Severity/ Psychotic/ Remission	Chronic	With Catatonic Features	With Melancholic Features	With Atypical Features	With Postpartum Onset
Major Depressive Disorder, Single Episode	X	X	X	X	X	X
Major Depressive Disorder, Recurrent	X	X	X	X	X	X

Dysthymic Disorder					X	
Bipolar I Disorder, Single Manic Episode	X		X			X
Bipolar I Disorder, Most Recent Episode Hypomanic						
Bipolar I Disorder, Most Recent Episode Manic	X		X			X
Bipolar I Disorder, Most Recent Episode Mixed	X		X			X
Bipolar I Disorder, Most Recent Episode Depressed	X	X	X	X	X	X
Bipolar I Disorder, Most Recent Episode Unspecified						
Bipolar II Disorder, Hypomanic						
Bipolar II Disorder, Depressed	X	X	X	X	X	X
Cyclothymic Disorder						

2) Severity/Psychotic/Remission Specifiers for Major Depressive Episode[47]

These specifiers apply to the most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode. If criteria are currently met for the Major Depressive Episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe With Psychotic Features. If the criteria are no longer met, the specifier indicates whether the episode is in partial or full remission. For Major Depressive Disorder and most of the Bipolar I Disorders, the specifier is reflected in the fifth-digit coding for the disorder.

Criteria For Severity/Psychotic/Remission Specifiers for Current (or Most Recent) Major Depressive Episode

Note: Code in fifth digit. Can be applied to the most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode.

.x1 – Mild: Few, if any, symptoms in excess of those required to make the diagnosis and symptoms result in only minor impairment in occupational functioning or in usual social activities or relationships with others.

.x2 – Moderate: Symptoms or functioning impairment between 'mild' and 'severe.'

.x3 – Severe Without Psychotic Features: Several symptoms in excess of those required to make the diagnosis, and symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

.x4 – Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

Mood-Congruent Psychotic Features: Delusions or hallucinations whose content is entirely consistent with the typical depressive themes of personal inadequacy, guilt, disease, death, nihilisms, or deserved punishment.

Mood-Incongruent Psychotic Features: Delusions or hallucinations whose content does not involve typical depressive themes of personal inadequacy, guilt, disease, death, nihilism, or deserved punishment. Included are such symptoms as persecutory delusions (not directly related to depressive themes), thought insertion, thought broadcasting and delusions of control.

.x5 – In Partial Remission: Symptoms of a Major Depressive Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Major Depressive Episode lasting less than 2 months following the end of the Major Depressive Episode. (If the Major Depressive Episode was superimposed on Dysthymic Disorder, the diagnosis of Dysthymic Disorder alone is given once the full criteria for a Major Depressive Episode are no longer met.)

.x6 – In Full Remission: During the past 2 months, no significant signs or symptoms of the disturbance were present.

.x0 – Unspecified.

3) Severity/Psychotic/Remission Specifiers for Manic Episode[48]

Criteria For Severity/Psychotic/Remission Specifiers for Current (Or Most Recent) Manic Episode

Note: Code in fifth digit. Can be applied to a Manic Episode in Bipolar I Disorder only if it is the most recent type of mood episode.

.x1 – Mild: Minimum symptom criteria are met for a Manic Episode.

.x2 – Moderate: Extreme increase in activity or impairment in judgement.

.x3 – Severe Without Psychotic Features: Almost continual supervision required to prevent physical harm to self or others.

.x4 – Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

Mood-Congruent Psychotic Features: Delusions or hallucinations whose content is entirely consistent with the typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person.

Mood-Incongruent Psychotic Features: Delusions or hallucinations whose content does not involve typical manic themes of inflated worth, power, knowledge, identity, or special relationship to a deity or famous person. Included are such symptoms as persecutory delusions (not directly related to grandiose ideas or themes), thought insertion, and delusions of being controlled.

.x5 – In Partial Remission: Symptoms of a Manic Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Manic Episode lasting less than 2 months following the end of the Manic Episode.

.x6 – In Full Remission: During the past 2 months no significant signs or symptoms of the disturbance were present.

.x0 – Unspecified.

4) Severity/Psychotic/Remission Specifiers for Mixed Episode[49]

Criteria For Severity/Psychotic/Remission Specifiers for Current (Or Most Recent) Mixed Episode

Note: Code in fifth digit. Can be applied to a Mixed Episode in Bipolar I Disorder only if it is the most recent type of mood episode.

.x1 – Mild: No more than minimum symptom criteria are met for both a Manic Episode and a Major Depressive Episode.

.x2 – Moderate: Symptoms or functional impairment between 'mild' and 'severe.'

.x3 – Severe Without Psychotic Features: Almost continual supervision required to prevent physical harm to self or others.

.x4 – Severe With Psychotic Features: Delusions or hallucinations. If possible, specify whether the psychotic features are mood-congruent or mood-incongruent:

Mood-Congruent Psychotic Features: Delusions or hallucinations whose content is entirely consistent with the typical manic or depressive themes.

Mood-Incongruent Psychotic Features: Delusions or hallucinations whose content does not involve typical manic or depressive themes. Included are such symptoms as persecutory delusions (not directly related to grandiose or depressive themes), thought insertion, and delusions of being controlled.

.x5 – In Partial Remission: Symptoms of a Mixed Episode are present but full criteria are not met, or there is a period without any significant symptoms of a Mixed Episode lasting less than 2 months following the end of the Mixed Episode.

.x6 – In Full Remission: During the past 2 months no significant signs or symptoms of the disturbance were present.

.x0 – Unspecified.

5) Chronic Specifier for a Major Depressive Episode[50]

Criteria for Chronic Specifier

Specify if:

Chronic (can be applied to the current or most recent Major Depressive Episode in Major Depressive Disorder and to a Major Depressive Episode in Bipolar I or II Disorder only if it is the most recent type of mood episode)

Full criteria for a Major Depressive Episode have been met continuously for at least the past 2 years.

6) Catatonic Features Specifier[51]

Criteria for Catatonic Features Specifier

Specify if:

With Catatonic Features (can be applied to the current or most recent Major Depressive Episode, Manic Episode, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder)

The clinical picture is dominated by at least two of the following:

(1) motoric immobility as evidenced by catalepsy (including waxy flexibility)or stupor

(2) excessive motor activity (that is apparently purposeless and not influenced by external stimuli)

(3) extreme negativism (an apparently motiveless resistance to all instructions or maintenance of a rigid posture against attempts to be moved) or mutism

(4) peculiarities of voluntary movement as evidenced by posturing (voluntary assumption of inappropriate or bizarre postures), stereotyped movements, prominent mannerisms, or prominent grimacing

(5) echolalia or echopraxia

7) Melancholic Features Specifier[52]

Criteria for Melancholic Features Specifier

Specify if:

With Melancholic Features (can be applied to the current or most recent Major Depressive Episode in Major Depressive Disorder

and to a Major Depressive Episode in Bipolar I or Bipolar II Disorder only if it is the most recent type of mood episode)

A. Either of the following, occurring during the most severe period of the current episode:

(1) loss of pleasure in all, or almost all, activities

(2) lack of reactivity to usually pleasurable stimuli (does not feel much better, even temporarily, when something good happens)

B. Three (or more) of the following:

(1) distinct quality of depressed mood (i.e., the depressed mood is experienced as distinctly different from the kind of feeling experienced after the death of a loved one)

(2) depression regularly worse in the morning

(3) early morning awakening (at least 2 hours before usual time of awakening)

(4) marked psychomotor retardation or agitation

(5) significant anorexia or weight loss

(6) excessive or inappropriate guilt

8) Atypical Features Specifier[53]

Criteria for Atypical Features Specifier

Specify if:

With Atypical Features (can be applied when these features predominate during the most recent 2 weeks of a Major Depressive Episode in Major Depressive Disorder or in Bipolar I or Bipolar II Disorder when the Major Depressive Episode is the most recent type of mood episode, or when these features predominate during the most recent 2 years of Dysthymic Disorder)

A. Mood reactivity (i.e., mood brightens in response to actual or potential positive events)

B. Two (or more) of the following features:

(1) significant weight gain or increase in appetite

(2) hypersomnia

(3) leaden paralysis (i.e., heavy, leaden feelings in arms or legs)

(4) long-standing pattern of interpersonal rejection sensitivity (not limited to episodes of mood disturbance) that results in significant social or occupational impairment.

C. Criteria are not met for With Melancholic Features or With Catatonic Features during the same episode.

9) Postpartum Onset Specifier[54]

Criteria for Postpartum Onset Specifier

Specify if:

With Postpartum Onset (can be applied to the current or most recent Major Depressive, Manic, or Mixed Episode in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder; or to Brief Psychotic Disorder)

Onset of episode within 4 weeks postpartum

SECTION - II

Specifiers Describing Course of Recurrent Episodes

15. Course Specifiers that apply to Mood Disorders[55]

Course Specifiers that apply to Mood disorders

Mood Disorders	With/Without Interepisode Recovery	Seasonal Pattern	Rapid Cycling
Major Depressive Disorder, Single Episode			
Major Depressive Disorder, Recurrent	X	X	
Dysthymic Disorder			
Bipolar I Disorder, Single Manic Episode			
Bipolar I Disorder, Most Recent Episode Hypomanic	X	X	X
Bipolar I Disorder, Most Recent Episode Manic	X	X	X
Bipolar I Disorder, Most Recent Episode Mixed	X	X	X
Bipolar I Disorder, Most Recent Episode Depressed	X	X	X
Bipolar I Disorder, Most Recent Episode Unspecified	X	X	X
Bipolar II Disorder, Hypomanic	X	X	X
Bipolar II Disorder, Depressed	X	X	X
Cyclothymic Disorder			

16. Longitudinal Course Specifiers[56]

(With and Without Full Interepisode Recovery)

Criteria for Longitudinal Course Specifiers

Specify if (can be applied to Recurrent Major Depressive Disorder or Bipolar I or II Disorder):

With Full Interepisode Recovery: if full remission is attained between the two most recent Mood Episodes

Without Full Interepisode Recovery: if full remission is not attained between the two most recent Mood Episodes

17. Seasonal Pattern Specifier[57]

Criteria for Seasonal Pattern Specifier

Specify if:

With Seasonal Pattern (can be applied to the pattern of Major Depressive Episodes in Bipolar I Disorder, Bipolar II Disorder, or Major Depressive Disorder, Recurrent)

A. There has been a regular temporal relationship between the onset of Major Depressive Episodes in Bipolar I or Bipolar II Disorder or Major Depressive Disorder, Recurrent, and a particular time of the year (e.g., regular appearance of the Major Depressive Episode in the fall or winter).

Note: Do not include cases in which there is an obvious effect of seasonal related psychosocial stressors (e.g., regularly being unemployed every winter).

B. Full remissions (or a change from depression to mania or hypomania) also occur at a characteristic time of the year (e.g., depression disappears in the spring).

C. In the last two years, two Major Depressive Episodes have occurred that demonstrate the temporal seasonal relationships defined in Criteria A and B, and no nonseasonal Major Depressive Episodes have occurred during that same period.

D. Seasonal Major Depressive Episodes (as described above) substantially outnumber the nonseasonal Major Depressive Episodes that may have occurred over the individual's lifetime.

18. Rapid-Cycling Specifier[58]

Criteria for Rapid-Cycling Specifier

Specify if:

With Rapid Cycling (can be applied to Bipolar I Disorder or Bipolar II Disorder)

At least four episodes of a mood disturbance in the previous 12 months that meet criteria for Major Depressive, Manic, Mixed or Hypomanic Episode.

Note: Episodes are demarcated either by partial or full remission for at least 2 months or a switch to an episode of opposite polarity (e.g., Major Depressive Episode to Manic Episode).

PART FOUR

TREATMENT

Antidepressants have become the predominant form of treatment for unipolar depression. A number of psychotherapies have been found to be as effective as antidepressants, especially in less severe cases of unipolar depression. Support alone with no medication may be effective for mild acute depression, whereas more severely depressed patients do best with antidepressants. The efficacies of specific psychotherapies appeared to be intermediate between placebo and medication and these psychotherapies may work

on different symptoms. Cognitive-behaviour psychotherapy and interpersonal therapy (IPT) are effective for severe depression. Interpersonal therapy and behavioural therapy may be less effective in melancholic than in nonmelancholic depression. Relapse of depression does not occur as rapidly after discontinuation of psychotherapy as it does after withdrawal of antidepressants, and continuation of psychotherapy after recovery reduces the relapse rate.[59]

19. Cognitive Therapy (CT)

Cognitive therapy is based on the premise that the negative emotions of depression are reactions to negative thinking derived from global dysfunctional negative attitudes. Patient and therapist work together to identify automatic negative thoughts, correct the pervasive beliefs that generate these thoughts, and develop more realistic basic assumptions. Treatment involves systematically monitoring negative cognitions whenever the patient feels depressed; recognizing the association between cognition, affect, and behaviour; generating data that support or refute the negative cognition; generating alternative hypotheses to explain the event that precipitated the negative cognition; and identifying the negative schemata predisposing to the emergence of global negative thinking when one side of an all-or-nothing assumption is disappointed. In the course of examining dysfunctional attitudes, the patient learns to label and counteract information processing errors such as overgeneralization, excessive personalization, all-or-nothing thinking, and generalizing from single negative events.

An example of the cognitive therapy would be a man who feels depressed at the thought 'nobody loves me' when his friend did not greet him enthusiastically. This thought might be seen to follow logically from the assumption 'If my friend is not always happy to see me, he does not love me.' Two kinds of alternative hypotheses could be generated in considering this cognition. First, the patient's friend may have been preoccupied with something else or may have been happy to see him but did not demonstrate it in exactly the way he expected. Second, lack of enthusiasm at one particular moment is not necessarily a sign of generalized lack of love. Eventually the patient learns to correct the underlying all-or-nothing belief 'People either are completely devoted to me or they do not care at all.'[60]

20. Interpersonal Therapy (IPT)

Interpersonal therapy is designed to improve depression by enhancing the quality of the patient's interpersonal world. The treatment begins with an explanation of the diagnosis and treatment options, legitimising depression as a medical illness. The acute course of treatment is conducted according to a manualized protocol over 12-16 weeks. A protocol for maintenance interpersonal therapy has also been developed. Through structured assignments, interpersonal therapy helps the patient to work toward explicit goals related to whichever of the four basic interpersonal problems (unresolved grief, role disputes, transitions to new roles, and social skills deficits) is believed to be present. Role-playing is used to help the patient acquire new interpersonal skills, and structured conjoint meetings are used to help partners to clarify their expectations of each other.[61]

21. Behaviour Therapy

Therapies for depression derived from principles of classic and operant conditioning, social learning theory, and learned helplessness include social learning approaches, self-control therapy, social skills training, and structured problem-solving therapy. Behaviour therapies utilize education, guided practice, homework assignments, and social reinforcement of successive approximations in a time-limited format, typically over 8-16 weeks. Depressive behaviours such as self-blame, passivity, and negativism are ignored, whereas behaviours that are inconsistent with depression, such as activity, experiencing pleasure, and solving problems, are rewarded. Rewards can include anything that the patient seems to seek out – from attention, to praise, to being permitted to withdraw or complain, to money. Learned helplessness is combated by the therapist's giving patients small, discrete tasks that very gradually become more demanding. For example, a person who is hopeless about finding a suitable job, is first of all asked to buy a newspaper; then go through the newspaper and list all the available jobs; then he is asked to choose one and make an application and the like. Each positive experience reinforces a feeling of accomplishment that makes the next task easier. Social skills training teaches self-reinforcement, assertive behaviour, and the use of social reinforcers such as eye contact and compliments.[62]

22. Psychodynamic Psychotherapy

At one time, extended and often unstructured psychodynamic psychotherapy was the standard psychotherapy for depression, and some case reports seemed to support its efficacy. With more experience, the utility of nondirective 'traditional' psychodynamic approaches as a treatment for depression (as opposed to character pathology) was increasingly questioned. There are no controlled studies of prolonged psychodynamic psychotherapy or psychoanalysis in mood disorders. Brief dynamic psychotherapies have been applied to depressive disorders, but they have not been studied as rigorously as have cognitive therapy and interpersonal therapy been.[63]

23. Characteristics of an Effective Psychotherapy for Depression[64]

Even though data from controlled studies of psychotherapy of depression are limited, certain characteristics have repeatedly emerged as distinguishing effective treatments, regardless of the technical details of the therapy. Extended, unstructured psychotherapies may be useful for treating associated problems such as personality disorders, but given the lack of data supporting the use of these therapies as primary treatments for depression, more focused, time-limited therapies seem appropriate, at least as initial approaches.

Characteristics of an Effective Psychotherapy for Depression

1. time limited
2. explicit rationale for treatment shared by patient and therapist
3. active and directive therapist
4. focus on current problems
5. emphasis on changing current behaviour
6. self-monitoring of progress
7. involvement of significant others
8. expression of cautious optimism
9. problems divided into manageable units with short-term goals
10. homework assignments

24. Combining Medications and Psychotherapy

Studies suggest that psychotherapies along with added antidepressants during the acute phase of treatment, found only a trend favouring a modest advantage for combined treatment. Until more informative data become available about mild to moderate unipolar nonpsychotic depression, the recommendation that such depressive episodes be treated initially either with antidepressants or with one of the focused psychotherapies for depression seems reasonable. Some experts suggest that more severe major depressive episodes be treated first with antidepressants alone. These experts recommend combining medication and psychotherapy for patients with an inadequate response to either modality, with multiple symptom clusters that might respond differentially to psychotherapy and medication, or with a previously chronic course.[65]

25. CONCLUSION

Mood disorders are not unitary illnesses but complex syndromes with distinct aetiologies, courses, and treatment responses. Even the most complete description of an affective episode at one point in time does not fully capture the picture of a mood disorder as it evolves over time. Mood disorders are not static but are dynamic conditions in which each new episode is a function of previous episodes.

The evolving course of mood disorders is the result of an incompletely understood interaction of genetics, environmental factors, and cell biology. In many cases, initial episodes appear in response to an external stress, usually a loss or separation, or an event that evokes strong arousal or helplessness. Mood in early episodes is often more reactive to the environment. The neurobiology of an initial affective episode may be less complex, because a single treatment is often effective, and the physiology as well as the psychology of abnormal mood remits completely with treatment in the absence of substantial genetics loading or overwhelming early adverse experience. If they are not too severe, early depressive episodes respond equally well to environmental manipulation, psychotherapy, or medications.

With succeeding affective episodes, the psychobiology of mania or depression becomes more deeply ingrained by processes such as kindling, resetting of synaptic connections, and changes in

gene expression induced by neurotransmitter, receptor, and second messenger responses to abnormal moods. At this state, dysregulated affect becomes part of the normal repertoire of the synapse. At the same time, negative thinking, withdrawal, social ineptitude, irritability, and other depressive behaviours elicit negative input from others, which reinforces feelings of helplessness and solidifies the patient's identity as someone who is unfulfilled, overwhelmed, unpredictable, impulsive, incompetent, or unreliable. As more time is spent in the neurobiology and the psychology of abnormal mood, remissions are less complete and the new recurrences develop with less provocation.

The later affective recurrences are more abrupt, more severe, and more complex, as additional systems are recruited into an abnormal state. Environmental manipulation and structured psychotherapies become less effective. It is easier to treat early episodes than it is to treat later episodes of unipolar or bipolar mood disorders. Complete treatment of early episodes and continuation of effective therapy reduce the risk of later, more refractory episodes. Denial, reluctance to acknowledge needing help because being helped feels like a sign of weakness, and pressure from family members make it difficult for people in the early stages of a mood disorder to recognize the seriousness of the illness.[66]

26. Decision Tree for Differential Diagnosis[67]

Differential Diagnosis of Mood Disorders

Depressed, elevated, expansive, or irritable mood.

1. Is it due to the direct physiological effects of a general medical condition?

   If yes, then it is Mood Disorder Due to a General Medical Condition.
2. If no to the 1st question, then is it due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or a toxin)?

   If yes, then it is Substance-Induced Mood Disorder.
3. If no to the 2nd question, is there an elevated, expansive, or irritable mood, at least 1-week duration with marked impairment or hospitalisation?

If yes, then it is Manic Episode.

4. If no to the 3rd question, is there an elevated, expansive, or irritable mood, at least 4-day duration with changes observable by others but less severe than a Manic Episode?

   If yes, then it is Hypomanic Episode.

5. If no to the 4th question, is there at least 2 weeks of depressed mood or loss of interest plus associated symptoms, and not better accounted for by Bereavement?

   If yes, then it is Major Depressive Episode.

6. If no to the 5th question, are criteria met for Manic Episode and Major Depressive Episode nearly every day for at least 1 week?

   If yes, then it is Mixed Episode.

7. If no to the 6th question, has there been a manic episode or a mixed episode?

   If yes, do psychotic symptoms occur at times other than during Manic Or Mixed Episodes?

   If no, then it is Bipolar I Disorder.

   If yes, has it occurred exclusively during Schizoafective Disorder?

   If yes, then it is Schizoaffective Disorder, Bipolar Type.

   If no, then it is Bipolar Disorder NOS (superimposed on a Psychotic Disorder).

8. If no to the 7th question, has there been a hypomanic episode and at least one major depressive episode ?

   If yes, then it is Bipolar II Disorder.

9. If no to the 8th question, are there 2+ years of hypomanic symptoms and periods of depressed mood?

   If yes, then it is Cyclothymic Disorder.

10. If no to the 9th question, are there clinically significant manic/hypomanic symptoms that do not meet criteria for a specific Bipolar Disorder?

    If yes, then it is Bipolar Disorder NOS.

11. If no to the 10th question, has there been a major depressive episode?

    If yes, do psychotic symptoms occur at times other than during Major Depressive Episodes?

    If no, then it is Major Depressive Disorder.

If yes, has it occurred exclusively during Schizoaffective Disorder?

If yes, then it is Schizoaffective Disorder, Depressive Type.

If no, then it is Depressive Disorder NOS. (Superimposed on Psychotic Disorder)

12. If no to the 11th question, is there a depressed mood, more days than not, for at least 2 years with associated symptoms?

    If yes, then it is Dysthymic Disorder.

13. If no to the 12th question, is there a depressed mood not meeting criteria for one of above Mood Disorders that develops in response to a stressor?

    If yes, then it is Adjustment Disorder With Depressed Mood.

14. If no to the 13th question, are there clinically significant depressive symptoms that do not meet criteria for a specific Mood Disorder?

    If yes, then it is Depressive Disorder NOS.

    If no, then it is No Mood Disorder (mood symptoms that are not clinically significant)

4
ANXIETY DISORDERS

1. Introduction

Most people experience some anxiety and fear at sometime or other. This is part of the normal adaptation phase and the means by which people grow up into a realistic awareness of threats and danger. When anxiety is appropriate to the circumstance, it is considered normal. When anxiety and fear are not related to the realistic circumstances and become a frequent or repeated response, that response has now become pathological. Anxiety has been variously referred to as universal, omnipresent and ubiquitous. Sometimes it is difficult to separate anxiety from depression.

Anxiety disorders are the most common of all psychiatric illnesses and result in considerable functional impairment and distress. DSM-II described an ill-defined condition of 'anxiety neurosis,' a term first coined by Freud in 1895, which included any patient suffering from chronic tension, excessive worry, frequent headaches, or recurrent anxiety attacks. However, subsequent findings suggested that discrete spontaneous panic attacks may be qualitatively dissimilar to other chronic anxiety states. Thus, DSM-III-R divided the category of anxiety neurosis into 'panic disorder' and 'generalized anxiety disorder.' DSM-IV subdivided panic disorder into panic disorder with and panic disorder without agoraphobia, as in DSM-III-R, depending on whether there is any secondary phobic avoidance.

In DSM-IV, several issues were clarified regarding the diagnosis and differential diagnosis of panic disorder. Panic attacks are known to occur not only in panic disorder but in other anxiety disorders as well. In these other disorders (e.g., specific phobia, social phobia, and PTSD - Post Traumatic Stress Disorder) panic attacks are situationally bound or cued – that is, they occur exclusively within the context of the feared situation. DSM-IV explicitly presents the definition of panic attacks independently of panic

disorder and specified that a panic attack can be unexpected (uncued), situationally bound (cued), or situationally predisposed. DSM-IV retains the distinct diagnoses of panic disorder with agoraphobia, social phobia, and specific phobia and specifies that panic attacks can occur as a feature of all three of these disorders. DSM-IV also sharpened the distinction of GAD (Generalized Anxiety Disorder) from 'normal' anxiety by specifying that in GAD, the worry must be clearly excessive, pervasive, difficult to control, and associated with marked distress or impairment.[1]

Mixed Anxiety-Depressive Disorder

Clinically both anxious and depressive symptoms seem to be present but do not meet the criteria for either an anxiety disorder or a depressive disorder. On the one hand, the condition is clinically identifiable and can cause notable distress and impairment, and may need treatment. On the other hand, there can be a risk of overdiagnosing psychiatric illness when it blends in with more universal human vicissitudes and of overmedicating with drugs that may not necessarily be effective on or specific to their target symptoms. As an interim solution, the diagnosis of mixed anxiety-depressive disorder has been included in an appendix to DSM-IV. It is a diagnosis of exclusion and stipulates a 1-month duration of symptoms; its institution may promote more conclusive research in this area.[2]

SECTION-I

PANIC DISORDER

2. Panic Attack[3]

Since panic attacks occur in the context of several different anxiety disorders, we treat panic attack separately. The essential feature of a panic attack is a discrete period of intense fear or discomfort that is accompanied by at least 4 of 13 somatic or cognitive symptoms. The attack has a sudden onset and builds to a peak rapidly (usually in 10 minutes or less) and is often accompanied by a sense of imminent danger or impending doom and an urge to escape. Attacks that meet all other criteria but that have fewer than 4 somatic or cognitive symptoms are referred to as limited-symptom attacks.

Patients with panic attacks will usually describe the fear as intense and report that they thought they were about to die, lose control, have heart attack or stroke, or 'go crazy.' They also usually report an urgent desire to flee from wherever the attack is occurring. Shortness of breath is a common symptom in panic attacks associated with panic disorder with and without agoraphobia. Blushing is common in situationally bound panic attacks related to social or performance anxiety. The anxiety that is characteristic of a panic attack can be differentiated from generalized anxiety by its intermittent, almost paroxysmal nature and its typically greater severity.

Panic attacks can occur in a variety of anxiety disorders. In determining the differential diagnostic significance of a panic attack, it is important to consider the context in which the panic attack occurs. There are three characteristic types of panic attacks with different relationships between the onset of the attack and the presence or absence of situational triggers:

1. Unexpected (uncued) panic attacks: In this the onset of the panic attack is not associated with a situational trigger (i.e., occurring spontaneously 'out of the blue');
2. Situationally bound (cued) panic attacks: In this the panic attack almost invariably occurs immediately on exposure to, or in anticipation of, the situational cue or trigger (e.g., seeing a dog always triggers an immediate panic attack);
3. Situationally predisposed panic attacks: In this the panic attack is more likely to occur on exposure to the situation cue or trigger, but is not invariably associated with the cue and does not necessarily occur immediately after the exposure (e.g., attacks are more likely to occur while driving, but there are times when the individual drives and does not have a panic attack or times when the panic attack occurs after driving for a half hour).

The occurrence of unexpected panic attacks is required for a diagnosis of panic disorder (with or without agoraphobia). Situationally bound panic attacks are most characteristic of social and specific phobias. Situationally predisposed panic attacks are especially frequent in panic disorder but may at times occur in specific phobia or social phobia. The differential diagnosis of panic attacks is complicated by the fact that an exclusive relationship does not always exist between the diagnosis and the type of panic attack.

Criteria for Panic Attack

Note: A Panic Attack is not a codable disorder. Code the specific diagnosis in which the Panic Attack occurs.

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

1. palpitations, pounding heart, or accelerated heart rate
2. sweating
3. trembling or shaking
4. sensations of shortness of breath or smothering
5. feeling of choking
6. chest pain or discomfort
7. nausea or abdominal distress
8. feeling dizzy, unsteady, lightheaded, or faint
9. derealization (feelings of unreality) or depersonalisation (being detached from oneself)
10. fear of losing control or going crazy
11. fear of dying
12. paresthesias (numbness or tingling sensations)
13. chills or hot flushes

3. Agoraphobia[4]

A phobia is defined as a persistent and irrational fear of a specific object, activity, or situation that results in a compelling desire to avoid the dreaded object, activity, or situation (i.e., phobic stimulus). The fear is recognized by the individual as excessive or unreasonable in proportion to the actual dangerousness of the object, activity, or situation. Irrational fears and avoidance behaviour are seen in a number of psychiatric disorders. However, in DSM-IV, phobic disorder is considered to be present only when single or multiple phobias are the predominant aspect of the clinical picture and a source of notable distress to the individual and are not the result of another mental disorder.

Phobias were classified in DSM-I under the rubric 'phobic reaction' and in DSM-II as 'phobic neurosis.' No subtypes were

listed in either edition. DSM-III markedly differed from the previous editions in classifying distinct subtypes of phobias, suggesting a qualitative distinction between these subtypes – agoraphobia, social phobia, and miscellaneous specific phobias. These three major categories of phobias were maintained in DSM-III-R and in DSM-IV. In DSM-III-R, agoraphobia was subdivided into panic disorder with agoraphobia and agoraphobia without panic disorder, which emphasizes the primacy of panic when the two conditions coexist. This classification is maintained in DSM-IV.

Agoraphobia can occur in the context of Panic Disorder With Agoraphobia and Agoraphobia Without History of Panic Disorder. The essential feature of Agoraphobia is anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having a Panic Attack or panic-like symptoms (e.g., fear of having a sudden attack of dizziness or a sudden attack of diarrhoea). The anxiety typically leads to a pervasive avoidance of a variety of situations; this may include being alone outside the home or being home alone; being in a crowd of people; travelling in an automobile, bus, or airplane; or being on a bridge or in an elevator.

Criteria for Agoraphobia

Note: Agoraphobia is not a codable disorder. Code the specific disorder in which the Agoraphobia occurs.

A. Anxiety about being in places or situations from which escape might be difficult (or embarrassing) or in which help may not be available in the event of having an unexpected or situationally predisposed Panic Attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; and travelling in a bus, train, or automobile.

   Note: Consider the diagnosis of Specific Phobia if the avoidance is limited to one or only a few specific situations, or Social Phobia if the avoidance is limited to social situations.

B. The situations are avoided (e.g., travel is restricted) or else are endured with marked distress or with anxiety about having a Panic Attack or panic-like symptoms, or require the presence of a companion.

C. The anxiety or phobic avoidance is not better accounted for by another mental disorder, such as Social Phobia (e.g., avoidance limited to social situations because of fear of embarrassment), Specific Phobia (e.g., avoidance limited to a single situation like elevators), Obsessive-Compulsive Disorder (e.g., avoidance of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., avoidance of leaving home or relatives).

4. Panic Disorder

Onset

In panic disorder, subjects are engaged in some ordinary aspect of life when suddenly their heart begins to pound and they cannot catch their breath. They feel dizzy, light-headed, and faint and are convinced they are about to die. Panic disorder patients are usually young adults, most likely in the third decade. However, there have been cases in which the disorder began in the sixth decade.

Although the first attack generally strikes during some routine activity, several events are often associated with the early presentation of panic disorder. The first panic attack might occur in the context of a life-threatening illness or accident, the loss of a close interpersonal relationship, or during separation from family (e.g., after starting college or accepting a job out of town). Patients developing either hypothyrodism or hyperthyroidism may get the first flurry of attacks at this time. Attacks may also begin in the immediate postpartum period. Many patients have reported experiencing their first attacks while taking mind-altering drugs especially marijuana, LSD, sedatives, cocaine, and amphetamines. All the same, even when these concomitant conditions are resolved, the attacks often continue unabated. One gets the impression that some stressors may act as triggers to provoke the beginning of panic attacks in people who are already predisposed.

Patients experiencing their first panic attack generally fear they are having a heart attack or losing their mind. After a physical examination and laboratory tests, they are reassured and sent home. However, perhaps a few days or even weeks later, they will

again have the sudden onset of severe anxiety with all of the associated physical symptoms. When medically tested, it will be known that the problem is psychological.[5]

Symptoms

Usually, during a panic attack, a patient will be engaged in a routine activity – perhaps reading a book, eating in a restaurant, driving a car, or attending a concert – when he/she will experience the sudden onset of overwhelming fear, terror, apprehension, and a sense of impending doom. Several of a group of associated symptoms, mostly physical, are also experienced: dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, dizziness or feelings of unsteadiness, feelings of unreality (derealization and/or depersonalisation), paresthesias, hot and cold flashes, sweating, faintness, trembling and shaking, and a fear of dying, going crazy, or losing control of oneself. Most of the physical sensations of panic attack represent massive overstimulation of the autonomic nervous system.

Attacks usually last from 5 to 20 minutes and rarely last as long as an hour. Patients who claim they have attacks that last a whole day may fall into one of the four following categories. Some patients continue to feel agitated and fatigued for several hours after the main portion of the attack has subsided. At times, attacks occur, subside, and occur again in a wave-like manner. Alternatively, the patient with so-called long panic attacks is often suffering from some other form of pathological anxiety, such as severe generalized anxiety, agitated depression, or obsessional tension states. In some cases such severe anticipatory anxiety may develop with time in expectation of future panic attacks so that the two may blend together in the patient's description and be difficult to distinguish.

Although many people experience an occasional unexpected attack of panic, the diagnosis of panic disorder is only made when the attacks occur with some regularity and frequency. Patients with occasional unexpected panic attacks may be genetically similar to patients with panic disorder.

Some patients do not progress in their illness beyond the point of continuing to have unexpected panic attacks. Most patients develop some degree of anticipatory anxiety consequent to the

experience of repetitive panic attacks. The patient comes to dread experiencing an attack and starts worrying about doing so in the intervals between attacks. This can progress until the level of fearfulness and autonomic hyperactivity in the interval between panic attacks almost approximates the level during the actual attack. Such cases should not be mistaken for Generalized Anxiety Disorder (GAD).

Hyperventilation may be the central feature in the pathophysiology of panic attacks and panic disorder. Patients with panic disorder have been shown to be chronic hyperventilators who also acutely hyperventilate during spontaneous and induced panic. This hyperventilation then induces hypocapnia and alkalosis, leading to decreased cerebral blood flow and to the dizziness, confusion, and derealization characteristic of panic attacks. Indeed, signs and symptoms of hyperventilation seem to disappear once a patient with panic disorder has been successfully treated with antipanic medication. Behavioural breathing retraining treatment aimed at teaching the patient not to hyperventilate is successful in decreasing the frequency of panic attacks, presumably through dampening the ventilatory overreaction that may constitute the hallmark of panic [6]

1) Panic Disorder without Agoraphobia[7]

Diagnostic Criteria for Panic Disorder without Agoraphobia

(DSM-IV Code: 300.01 & ICD-10 Code: F41.0)

A. Both (1) and (2)
   (1) recurrent unexpected Panic Attacks
   (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
   (a) persistent concern about having additional attacks
   (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, 'going crazy')
   (c) a significant change in behaviour related to the attacks

B. Absence of Agoraphobia

C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).

D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

2) Panic Disorder with Agoraphobia[8]

Diagnostic Criteria for Panic Disorder with Agoraphobia

(DSM-IV Code: 300.21 & ICD-10 Code:F40.01)

A. Both (1) and (2)
   (1) recurrent unexpected Panic Attacks
   (2) at least one of the attacks has been followed by 1 month (or more) of one (or more) of the following:
      (a) persistent concern about having additional attacks
      (b) worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, 'going crazy')
      (c) a significant change in behaviour related to the attacks
B. The presence of Agoraphobia
C. The Panic Attacks are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism).
D. The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations), Specific Phobia (e.g., on exposure to a specific phobic situation), Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor), or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

3) Differential Diagnosis[9]

In Common with	Characteristics Shared	Exclusively characteristic of Panic Disorder or of the disorder with which it is compared or difference between the two disorders
Anxiety Disorder Due to a General Medical Condition	Panic Attack	Panic Attacks are due to a direct physiological consequence of a general medical condition
Substance-Induced Anxiety Disorder	Panic Attacks	Panic Attacks are due to a direct physiological consequence of a substance
Mental Disorders (e.g., other anxiety disorders and psychotic disorders)	Panic Attacks	For the mental disorders the Panic Attacks are an associated feature. For the other anxiety disorders, unlike Panic Disorder, Panic Attacks are situationally bound or situationally predisposed. In Panic Disorder the Panic Attacks occurs unexpectedly.

5. Agoraphobia Without History of Panic Disorder

The essential features of Agoraphobia Without History of Panic Disorder are similar to those of Panic Disorder With Agoraphobia except that the focus of fear is on the occurrence of incapacitating or extremely embarrassing panic-like symptoms or limited-symptoms attacks rather than full Panic Attacks. Individuals with this disorder have Agoraphobia. The 'panic-like symptoms' include any of the 13 symptoms listed for panic Attack or other symptoms that may be incapacitating or embarrassing (e.g., loss of bladder control). To qualify for this diagnosis, the full criteria for Panic Disorder must never have been met and the symptoms must not be due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition. If an associated general medical condition is present (e.g., a

cardiac condition), the fear of being incapacitated or embarrassed by the development of symptoms (e.g., fainting) is clearly in excess of that usually associated with the condition.

1) Diagnostic Criteria[10]

Diagnostic Criteria for Agoraphobia without History of Panic Disorder

(DSM-IV Code: 300.22 & ICD-10 Code: F40.00)

A. The presence of Agoraphobia related to fear of developing panic-like symptoms (e.g., dizziness or diarrhoea).

B. Criteria have never been met for Panic Disorder.

C. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

D. If an associated general medical condition is present, the fear described in Criterion A is clearly in excess of that usually associated with the condition.

2) Differential Diagnosis[11]

In Common with	Characteristics Shared	Exclusively characteristic of Agoraphobia Without History of Panic Disorder or of the disorder with which it is compared or difference between the two disorders
Panic Disorder With Agoraphobia	Panic Attacks	In Panic Disorder with Agoraphobia there is a history of recurrent unexpected Panic Attacks
Social Phobia	Avoidance	In Social Phobia avoidance is limited to social situations only
Specific Phobia	Avoidance	In Specific Phobia avoidance is limited to one or only a few specific situations
Major Depressive Disorder	Avoidance	Here avoidance of leaving home is due to apathy, loss of energy, and anhedonia
Delusional Disorder	Avoidance	Here avoidance is due to persecutory fears
Obsessive-Compulsive Disorder	Avoidance	Here avoidance is due to fears of contamination
Separation Anxiety Disorder	Avoidance	Here children avoid situations that take them away from home or close relatives
Individuals with certain general medical condition	Avoidance	Here individuals may avoid situations due to realistic concerns about being incapacitated (i.e. being embarrassed with diarrhoea)

6. Specific Phobia (Formerly Simple Phobia)

(DSM-IV Code: 300.29 & ICD-10 Code: F40.2)

Specific phobias are circumscribed fears of specific objects, situations, or activities. This syndrome has three components: 1. an anticipatory anxiety that is brought on by the possibility of confrontation with the phobic stimulus, 2. the central fear itself, and 3. the avoidance behaviour by which the patient minimizes anxiety. In specific phobia, the fear is usually not of the object itself but of some dire outcome that the individuals believe may result from contact with that object. For example, individuals with snake phobia are afraid that they will be bitten. These fears are excessive, unreasonable, and enduring; although most individuals with specific phobias will readily acknowledge that they know there is really nothing to be afraid of, reassuring them of this does not diminish their fear. In DSM-IV, for the first time, types of specific phobias have been adopted: natural environment (e.g., storms); animal (e.g., insects); blood-injury-injection; situational (e.g., cars, elevators, bridges); and other (e.g., choking, vomiting).

1) Diagnostic Criteria[12]

Diagnostic Criteria for Specific Phobia

A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging. (Fears are very common, particularly in childhood, but they do not warrant a diagnosis of specific phobia unless there is significant interference with social, educational, or occupational functioning or marked distress about having the phobia).

C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.

D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder With Agoraphobia, or Agoraphobia Without History of Panic Disorder.

Subtypes

The following subtypes may be specified to indicate the focus of fear or avoidance in Specific Phobia (e.g., Specific Phobia, Animal Type)

Animal Type: This subtype should be specified if the fear is cued by animals or insects. This subtype generally has a childhood onset.

Natural Environment Type: This subtype should be specified if the fear is cued by objects in the natural environment, such as storms, heights, or water. This subtype generally has a childhood onset.

Blood-Injection-Injury Type: This subtype should be specified if the fear is cued by seeing blood or an injury or by receiving an injection or other invasive medical procedure. This subtype is highly familial and is often characterized by a strong vasovagal response.

Situational Type: This subtype should be specified if the fear is cued by a specific situation such as public transportation, tunnels, bridges, elevators, flying, driving, or enclosed places. This subtype has a bimodal age-at-onset distribution, with one peak in childhood and another peak in the mid-20s. This subtype appears to be similar to Panic Disorder With Agoraphobia in its characteristic sex ratios, familial aggregation pattern, and age at onset.

Other Type: This subtype should be specified if the fear is cued by other stimuli. These stimuli might include the fear or avoidance of situations that might lead to choking, vomiting, or contracting an illness; 'space' phobia (i.e., the individual is afraid of falling down if away from walls or other means of physical support); and children's fear of loud sounds or costumed characters.

2) Differential Diagnosis[13]

In Common with	Characteristics Shared	Exclusively characteristic of Specific Phobia or of the disorder with which it is compared or difference between the two disorders
Panic Disorder With Agoraphobia	Fear	Unlike specific phobia, it has pervasive anxiety
Social Phobia	Fear	(i.e., The focus of fear in eating in a restaurant): in social phobia, it is due to the negative evaluation; in specific phobia, it is due to concerns about choking.
Posttraumatic Stress Disorder	Avoidance	Due to a life-threatening stressor unlike in specific phobia
Obsessive-Compulsive Disorder	Avoidance	Unlike in specific phobia, the avoidance is associated with the content of obsession (e.g., dirt, contamination)
Hypochondriasis	Fear	Hypochondriasis – fear of having a disease; specific phobia – fear of contracting a disease

Schizophrenia or another psychotic disorder	Avoiding certain activities	Unlike specific phobia, the avoidance is due in response to delusions and does not recognize that the fear is excessive or unreasonable

7. Social Phobia(Social Anxiety Disorder)

(DSM-IV Code: 300.23 & ICD-10 Code: F40.1)

In social phobia, the individual's central fear is that they will act in such a way that they will humiliate or embarrass themselves in front of others. Socially phobic individuals fear and/or avoid a variety of situations in which they would be required to interact with others or to perform a task in front of other people. Typical social phobias are phobias of speaking, eating or writing in public; of using public lavatories; and of attending parties or interviews. In addition, a common fear of socially phobic individuals is that other people will detect and ridicule their anxiety in social situations. An individual may have a single social fear or limited or numerous social fears. Social phobia is described as 'generalized' if the social fear encompasses most social situations as opposed to being present in circumscribed ones. Generalized social phobia is overall a more serious and impairing condition. This phobia can be reliably diagnosed as a subtype and involves an earlier age at onset than does limited social phobia; patients with generalized social phobia are more often single and have more interactional fears; and there is greater comorbidity with atypical depression and alcoholism.

As in specific phobia, the anxiety in social phobia is stimulus-bound. When forced or surprised into the phobic situation, the individual experiences profound anxiety accompanied by a variety of somatic symptoms. Blushing is the cardinal physical symptoms characteristic of social phobia, whereas commonly encountered cognitive symptoms include tendencies toward self-focused attention, negative self-evaluation regarding social performance, difficulty gauging nonverbal aspects of one's behaviour, discounting of social competence in positive interactions, and a positive bias towards appraising others' social performance.

Individuals who have only limited social fears may be functioning well overall and may be relatively asymptomatic unless

confronted with the necessity of entering their phobic situation. When faced with this necessity, they are often subject to intense anticipatory anxiety. Multiple social fears, on the other hand, can lead to chronic demoralization, social isolation, and disabling vocational and interpersonal impairment. Alcohol and sedative drugs are often used to alleviate at least the anticipatory component of this anxiety disorder, and substance abuse may result.

1) Diagnostic Criteria[14]

Diagnostic Criteria for Social Phobia

(Social Anxiety Disorder)

A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.

B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrum, freezing, or shrinking from social situations with unfamiliar people.

C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.

D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

F. In individuals under age 18 years, the duration is at least 6 months.

G. The fear or avoidance is not due to the direct physiological effect of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agora-

phobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).

H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behaviour in Anorexia Nervosa or Bulimia Nervosa.

Specify if:

Generalized: if the fears include most social situations (also consider the additional diagnosis of Avoidant Personality Disorder)

2) Differential Diagnosis[15]

In Common with	Characteristics Shared	Exclusively characteristic of Social Phobia or of the disorder with which it is compared or difference between the two disorders
Panic Disorder With Agoraphobia	Avoidance	Unlike social phobia, it has recurrent unexpected Panic Attacks
Agoraphobia Without History of Panic Disorder	Avoidance	Social phobia – situation avoided are limited to those involving possible scrutiny by other people; Agoraphobia without history of panic disorder – characteristic clusters of situations that may or may not involve scrutiny by others (e.g., being alone outside the home)
Separation Anxiety Disorder	Avoidance	Unlike social phobia, children with separation anxiety disorder, may avoid social settings due to concerns about being separated from their caretakers

Generalized Anxiety Disorder or Specific Phobia	Avoidance	Unlike social phobia, they do not have fear of embarrassment or humiliation as the main focus of fear or anxiety
Pervasive Developmental Disorder & Schizoid Personality Disorder	Avoidance of social situations	Unlike social phobia, it is due to the lack of interest in relating to other individuals
Performance anxiety, stage fright, and shyness	Fear	Unlike social phobia, they do not lead to clinically significant impairment or marked distress

Having dealt with phobia (as a constituent in Anxiety Disorders) let us now consider aetiology, course and prognosis and treatment of phobia.

8. Aetiology

1) Psychodynamic Theory

Freud (1895) remarked that in the analysis of phobias, 'nothing is ever found but the emotional state of anxiety.' In the case of agoraphobia we often find the recollection of an anxiety attack; and what the patient actually fears is the occurrence of such an attack under the special conditions in which he believes he cannot escape it. At that time Freud did not consider phobias to be psychologically mediated but thought that they are like anxiety neurosis, manifestations of a physiologically induced tension state. Undischarged libidinal energy was physiologically transformed into anxiety, which became attached to and partly discharged through objects that were, by their nature or in the patient's prior experience, dangerous.

With the 1909 publication of the case of Little Hans, Freud started to develop a more psychological theory of phobic symptom formation. Freud hypothesized that Little Hans's unconscious and forbidden sexual feelings for his mother and aggressive, rival-

rous feelings for his father, blocked from discharge because of repression, became physiologically transformed into anxiety, which was then displaced onto a symbolic object, in this case horses, the avoidance of which partly relieved Little Hans's anxiety.

Later in his evolving structural theory, Freud hypothesized that phobic symptoms occur as part of the resolution of intrapsychic conflict between instinctual impulses, superego prohibitions, and external reality constraints. Signal anxiety is experienced by the ego when such unconscious impulses threaten to break through. Such anxiety serves to mobilize not only further repression but also, in the case of phobia formation, projection and displacement of the conflict onto a symbolic object, which can then be avoided as a neurotic solution to the original conflict. In the case of Little Hans, sexual feelings for his mother, aggressive feelings towards his father, and the guilty fear of retribution and castration by his father generated anxiety as a signal of Oedipal conflict. The conflict became displaced and projected onto an avoidable object, horses, which Little Hans consequently feared would bite him. For Freud, such a phobic symptom had two advantages. It allowed Little Hands to avoid the ambivalence inherent in his original conflict – Little Hans not only hated but also loved his father. It also allowed his ego to cease generating anxiety as long as he could avoid the sight of horses. The cost of this compromise was that the boy became housebound. Of late, the psychodynamic literature has to a degree shifted away from formulations that primarily emphasize libidinal wishes and castration fears in understanding phobias.[16]

2) Conditioned Reflex Theories

In learning theory, phobic anxiety is thought to be a conditioned response that is acquired through association of the phobic object (i.e., the conditioned stimulus) with a noxious experience (i.e., the unconditioned stimulus). This classic learning theory model of phobias received much reinforcement from the relative success of behavioural (i.e., deconditioning) techniques in the treatment of many patients with simple phobia. However it is being criticized on the following grounds: 1. Many cases of phobia do not appear to have begun with a traumatic incident in which the phobic object is associated with an unpleasant unconditioned stimulus. 2. The learning theory model suggests that any object or

situation that is regularly associated with noxious stimuli has an equal likelihood of becoming a phobic object. But the range of phobic objects is actually relatively small and is neither random nor predominantly made up of those items that in a society might be most likely to be frequently associated with noxious stimuli (e.g., electric switches, stoves, oncoming cars). 3. Learning theory does not account for the qualitative distinctions between panic and anticipatory anxiety delineated by pharmacological and sodium lactate infusion studies.[17]

3) Biological Theories

Certain hypotheses about the origin of phobias have resulted from integration of ethological, biological, and learning theory approaches.

Seligman (1971) suggested that simple phobias are an example of evolutionarily prepared learning. The term 'preparedness' refers to the observation that certain responses to stimuli are more easily learned than others and that the ease of learning in any one instance varies from species to species. Preparedness is a measure of the ease with which a particular stimulus becomes paired with a particular response. Most specific phobias involve stimuli that over the course of evolution might have been dangerous to humans and are still reacted to as though they were intrinsically dangerous. In support of a biological component in specific phobias, Fyer et al. (1990) found high familial transmission for specific phobias.

Social phobia symptoms are accompanied in perhaps 50% of cases by a surge of plasma epinephrine. Such a surge distinguishes them from panic attacks, in which an adrenaline surge is not regularly seen. Patients with social phobia exhibit a blunted growth-hormone response to clonidine challenge, which suggests underlying noradrenergic dysfunction similar to that seen in panic disorder patients. Cognitive features also play a role in social phobia, because rapid infusions of adrenaline in nonperformance situations do not fully reproduce the symptoms. Agoraphobia is a response, in most cases, to spontaneous panic attacks. Why only some individuals with panic attacks develop agoraphobia is uncertain and involves an interplay of environmental, gender, and genetic features.[18]

9. Course and Prognosis

The usual age at onset of agoraphobia is between 18 and 35 years. Individuals whose panic episodes are characterized principally by feelings of unsteadiness and of falling typically have onset of the disorder in their 40s. The illness usually waxes and wanes and that many patients have at least brief periods of improvement or even remission.

Onset of social phobia is mainly in adolescence and early adulthood, earlier than the onset of agoraphobia, and the course of illness is very chronic. Onset of symptoms is sometimes acute after a humiliating social experience but is usually insidious over months or years and without a clear-cut precipitant. Predictors of good outcome in social phobia are onset after age 11 years, absence of psychiatric comorbidity, and higher educational status.

Animal phobias usually begin in childhood, whereas situational phobias tend to start later in life. The mean age at onset for animal phobias is 4.4 years, whereas patients with situational phobias have a mean age at onset of 22.7 years. Usually specific phobias follow a chronic course unless treated.[19]

10. Treatment

1) Pharmacotherapy

Agoraphobia: Antipanic medication is given to block the occurrence of panic attacks, and its efficacy is well documented. However, medication alone is often not adequate treatment in patients with significant agoraphobic avoidance. Some means of exposing agoraphobic patients to the feared situations is necessary for overall improvement. Such exposure may be achieved by various nonspecific methods such as psychoeducation, reassurance, and supportive therapy. Focused cognitive-behaviour therapy(CBT) is more successful than nonspecific techniques in reducing agoraphobic avoidance. Cognitive therapy has been shown to decrease panic attacks but not agoraphobia, whereas exposure reduces agoraphobia but not panic.

Social Phobia: Certain medication options are clearly efficacious in social phobia. Many performing artists or public speakers find that b–blockers, taken orally a few hours before stage time, reduce palpitations, tremor, and the 'butterfly feeling.' Although

a variety of b–blockers are probably efficacious for performance anxiety, the most common ones used are propranolol (20mg) or atenolol (50mg). b–blockers are more effective in controlling stage fright, with minimal or no side effects, than are benzodiazepines, which may decrease subjective anxiety but not optimise performance and may have an adverse effect on 'sharpness.' Monoamine oxidase inhibitors (MAOI) have proved to be the most effective medications for treating generalized social phobia. Several recent studies indicate that selective serotonin reuptake inhibitors (SSRIs) have been positive.

Specific Phobias: No medication has been shown to be effective in treating specific phobias.[20]

2) Cognitive-Behaviour Therapy

The goal of psychotherapeutic intervention in agoraphobia is to encourage patients to reenter the phobic situation and demonstrate to themselves that they will not have panic attacks while taking medication and therefore may give up both the avoidance and the worry, or anticipatory anxiety, about having attacks.

At the start of treatment, the therapist explains to the patient the three-stage development of the illness and the fact that the medication will block the spontaneous panics but may not alleviate anticipatory anxiety or the desire to avoid. Once the frequency of spontaneous panics has abated, some patients will begin to try out previously avoided situations on their own. Others will need structured encouragement in the form of supportive psychotherapy. On the whole, focused behaviour therapies appear to be more effective for patients with more severe or resistant agoraphobia; exposure techniques have been used in conjunction with antipanic medication in the treatment of patients with agoraphobia with panic attacks. A popular form of behaviour therapy is group in vivo exposure, in which groups of agoraphobic patients (initially accompanied by the therapist) travel together to restaurants, shopping malls, and other locations. Self-help groups are also helpful for raising the morale and sharing information among agoraphobic individuals. It appears that combination treatments (medication and psychotherapy) is positive, at least for those patients who are resistant to either form of treatment alone.

Social Phobia

The major cognitive-behaviour techniques are used in the treatment of social phobia: exposure, cognitive restructuring, and social skills training. Exposure treatment involves imaginal or in vivo exposure to specific feared performance and social situations. Although patients with very high levels of social anxiety may need to start out with imaginal exposure until a certain degree of habituation is attained, therapeutic results are not gained until in vivo exposure is done to the real-life feared situations. Social skills training employs modelling, rehearsal, role-playing, and assigned practice to help individuals learn appropriate behaviour and to decrease anxiety in social situations. This type of training is more applicable to those who have actual deficits in social interacting above and beyond their anxiety or avoidance of social situations. Cognitive restructuring focuses on poor self-concepts, the fear of negative evaluation by others, and the attribution of positive outcomes to chance or circumstance and negative outcomes to one's own shortcomings. In fine, cognitive-behaviour techniques lead to long-lasting gains and therefore may be of particular importance in this disorder, which tends to have a chronic, often lifetime, course. At this point, in vivo exposure is a critical component of the treatment and that the introduction of cognitive restructuring at some point in the treatment contributes to further gains and to their long-term maintenance.

Specific Phobias

The treatment of choice for specific phobias is exposure. Exposure treatment may be divided into two groups, depending on whether exposure to the phobic object is in vivo or imaginal. In vivo exposure involves the patient in real-life contact with the phobic stimulus. When imagial techniques are used, the phobic stimulus is confronted through the therapist's descriptions and the patient's imagination.

The method of exposure in both the in vivo and imaginal techniques can be graded or ungraded. Graded exposure uses a hierarchy of anxiety-provoking events, varying from least to most stressful. The patient begins at the least stressful level and gradually progresses up the hierarchy. Ungraded exposure begins with the patients confronting the most stressful items in the hierarchy.

Most exposure techniques have been used in both individual and group settings. In a group setting, both the example and the encouragement of other members are often particularly helpful in persuading the patient to reenter the phobic situation. Techniques may include systematic desensitisation, imagial flooding, prolonged in vivo exposure, and participant modelling and reinforced practice.[21]

3) Other Psychotherapy

Psychodynamic therapy for phobias does not have encouraging results. However, in those patients in whom underlying conflicts associated with phobic anxiety and avoidance can be identified by the therapist and lend themselves to insightful exploration, psychodynamic therapy may be beneficial. Furthermore, a psychodynamic approach may be valuable in understanding and resolving the secondary interpersonal ramifications in which phobic patients and their partners are often caught up and that could serve as resistance to the successful implementation of medication or behavioural treatments.[22]

SECTION-II

OBSESSIVE-COMPULSIVE DISORDER

11. Obsessive-Compulsive Disorder

(DSM-IV Code: 300.3 & ICD-10 Code: F42.8)

The essential features of obsessive-compulsive disorder (OCD) are obsession and/or compulsions. The terms 'obsession' and 'compulsion' are sometimes used to characterize conditions that are not true OCD. Although some activities such as eating, sexual behaviour, gambling, or drinking when engaged in excessively may be referred to as 'compulsive,' these activities are distinguished from true compulsions in that they are experienced as pleasurable and ego-syntonic, although their consequences may become increasingly unpleasant and ego-dystonic over time. Obsessive brooding, ruminations, or preoccupations, typically characteristic of depression, may be unpleasant but are distinguished from true obsessions because they are not as senseless or intrusive and the individual regards them as meaningful although possibly excessive and painful.

The several presentation of OCD are based on symptom clusters. One group includes patients with obsessions about dirt and contaminations, patients whose rituals centre around compulsive washing and avoidance of contaminated objects. A second group engages in pathological counting and compulsive checking. A third group includes purely obsessional patients with no compulsions. Primary obsessional slowness is evident in another group of patients, in whom slowness is the predominant symptom. Some are called 'hoarders' who are unable to throw away anything out for fear they might someday need something they have discarded.

In DSM-IV, OCD is classified among the anxiety disorders because 1. anxiety is often associated with obsessions and resistance to compulsions, 2. anxiety or tensions is often immediately relieved by yielding to compulsions, and 3. OCD often occurs in association with other anxiety disorders. However, compulsions decrease anxiety only transiently, and the nature of the fears in OCD is distinct from that in other anxiety disorders. Although more than 90% of patients have features of both obsessions and compulsions, 28% are bothered mainly by obsession, 20% by compulsions, and 50% by both.[23]

1) Diagnostic Criteria[24]

Diagnostic Criteria for Obsessive-Compulsive Disorder

A. Either obsessions or compulsions:

Obsessions as defined by (1), (2), (3), and (4):

(1) recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress

(2) the thoughts, impulses, or images are not simply excessive worries about real-life problems

(3) the person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action

(4) the person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsion as defined by (1) and (2)

(1) repetitive behaviours (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly

(2) the behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive

B. At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable. Note: This does not apply to children.

C. The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

D. If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder, hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

E. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Poor Insight: if, for most of the time during the current episode, the person does not recognize that the obsessions and compulsions are excessive or unreasonable

2) Onset

Obsessive-compulsive disorder usually begins in adolescence or early adulthood but can begin before that time; 31% of first episodes occur between ages 10 and 15 years and 75% develop by

age 30 years. In most cases, no particular stress or event precipitates the onset of OCD symptoms, and after an insidious onset there is a chronic and often progressive course. However, some patients describe a sudden onset of symptoms especially those with a neurological basis for their illness. The illness can also be associated with the encephalitis epidemic, abnormal birth events, seizures and pregnancy.[25]

3) Symptoms

(1) Obsessions

Obsessive and compulsive symptoms were first described by Esquirol in 1838. Obsessional thoughts were defined by Karl Westphal in 1878 as 'ideas that in an otherwise intact intelligence, and without being caused by an emotion . . . come into the foreground of the conscious.' An obsession is an intrusive, unwanted mental event usually evoking anxiety or discomfort. Obsessions may be thoughts, ideas, images, ruminations, convictions, fears, or impulses and are often of an aggressive, sexual, religious, disgusting, or nonsensical nature. Obsessional ideas are repetitive thoughts that interrupt the normal train of thinking, whereas obsessional images are often vivid visual experiences. Much obsessive thinking involves horrific ideas. The person may think of doing the worst possible thing (e.g., blasphemy, rape, murder, child molestation). Obsessional convictions are often characterized by an element of magical thinking, such as 'step on the crack, break your mother's back.' Obsessional ruminations may involve prolonged, excessive, and inconclusive thinking about metaphysical questions. Obsessional fears often involve dirt or contamination and differ from phobias in that they are present in the absence of the phobic stimulus. Other obsessional fears have to do with harm coming to oneself or to others as a consequence of the patient's misdoing. Obsessional impulses may be aggressive or sexual, such as intrusive impulses of stabbing one's spouse or raping one's child. Resistance is the struggle against an impulse or intrusive thought, and control is the patient's ability to divert his or her thinking. Obsessions are usually accompanied by compulsions but may also occur as the main or only symptom. Another hallmark of obsessive thinking involves lack of certainty or persistent doubting. They are unable to achieve a sense of certainty between incoming sensory information and internal beliefs. They keep asking questions

like 'Are my hands clean?' and 'Are the doors locked?' Compulsive rituals such as excessive washing or checking appear to arise from this lack of certainty and are misguided attempts to increase certainty.[26]

(2) Compulsions

A compulsive ritual is a behaviour that usually reduces discomfort but is carried out in a pressured or rigid fashion. Such behaviour may include rituals involving washing, checking, repeating, avoiding, striving for completeness, and being meticulous. Washers represent about 25%-50% of most OCD samples. They are concerned with dirt, contaminants, or germs and may spend many hours a day washing their hands or showering. They may also attempt to avoid contaminating themselves with faeces, urine, or vaginal secretions. Checkers have pathological doubt and thus compulsively check to see whether they have, for example, left the door unlocked. Checking often fails to resolve the doubt and in some cases may actually exacerbate it. Although slowness results from most rituals, it is the major feature of the rare and disabling syndrome of primary obsessional slowness. It may take several hours for this patient to get dressed or get out of the house. This slowness may be a response to a lack of certainty as well. These patients may have little anxiety despite their obsessions and rituals.

Mental compulsions are also quite common. Such patients, for example, may replay over and over in their minds past conversations with others to make sure they did not somehow incriminate themselves. Although distinct symptoms clusters exist (washers, checkers, those who are purely obsessional, hoarders, and those with primary slowness), these symptoms may overlap or develop sequentially.[27]

(3) Character Traits

Psychoanalytic theorists have suggested that there is a continuum between compulsive personality and OCD. They say that all obsessional patients have a premorbid personality that is causally related to the disorder. Freud noted an association between obsessional neurosis(i.e., OCD) symptoms and personality traits such as obstinacy, parsimony, punctuality, and orderliness. However, phenomenological evidence suggests that OCD is frequently distinct from obsessive-compulsive personality disorder.[28]

4) Aetiology

(1) Psychodynamic Theory

Psychodynamic theory views OCD as residing on a continuum with obsessive-compulsive character pathology and suggests that OCD develops when defence mechanisms fail to contain the obsessional character's anxiety. In this model, obsessive-compulsive pathology involves fixation and subsequent regression from the Oedipal to the earlier, anal developmental phase. The fixation is presumably due to excessive investment in anal eroticism, resulting from excessive frustrations or gratifications in the anal phase.

Obsessive-compulsive patients are thought to use the defence mechanisms of isolation, undoing, reaction formation, and displacement to control unacceptable sexual and aggressive impulses. The defence mechanisms are unconscious and thus not readily apparent to the patient.

Isolation: Isolation is an attempt to separate the feelings or affects from the thoughts, fantasies, or impulses that are associated with them. For example a patient may describe a particularly gruesome thought or fantasy but denies any feelings of anxiety or disgust associated with it.

Undoing: Undoing is an attempt to reverse a psychological event, such as a word, thought, or gesture. An act can be undone by performing or evoking its opposite. For example, an individual who believes that he/she has spent too much on an item for his/her pleasure, may punish himself/herself through some other deprivation.

Reaction Formation: In this an unacceptable unconscious impulse is substituted with its opposite. A patient who has sadistic impulses to hurt people might behave in a passive or masochistic manner or pronounce his love excessively at moments of heightened anger.[29]

Regression: In OCD, regression is theorized to take place from the genital Oedipal phase to the earlier pregenital anal-sadistic phase, which has not been fully relinquished. This regression helps the patient avoid genital conflicts and the anxiety associated with them. Themes characteristic of the anal phase typically reflect conflicts surrounding ambivalence, control, dirt, order, and parsimony.

Ambivalence: In normal development, aggressive impulses are neutralized and loving feelings predominate toward significant objects. In OCD, strong aggressive impulses are thought to re-emerge toward love objects, resulting in displaced ambivalence and paralysing doubts. In addition, magical ideation and lack of certainty may predominate, such that thoughts of harming someone may lead to uncertainty over actually having harmed someone.

(2) Learning Theory

A prominent behavioural model of the acquisition and maintenance of obsessive-compulsive symptoms derives from the two-stage learning theory of Mowrer(1939). In stage 1, anxiety is classically conditioned to a specific environmental event (e.g., classical conditioning). The person then engages in compulsive rituals (escape/avoidance responses) to decrease anxiety. If the individual is successful in reducing anxiety, the compulsive behaviour is more likely to occur in the future (stage 2: operant conditioning). Higher-order conditioning occurs when other neutral stimuli such as words, images, or thoughts are associated with the initial stimulus and the associated anxiety is diffused. Ritualised behaviour preserves the fear response, because the person avoids the eliciting stimulus and thus avoids extinction. Likewise, anxiety reduction following the ritual preserves the compulsive behaviour.[30]

(3) Biological Theories

The association of OCD with a variety of neurological conditions or more subtle neurological findings has been known for some time. They are as follows: 1. The onset of OCD following head trauma, 2. A high incidence of neurological premorbid illnesses in OCD, 3. An association of OCD with birth trauma, 4. Abnormalities on the electroencephalogram, auditory evoked potentials, and ventricular brain ratio on computed tomography scan, 5. An association with diabetes insipidus and 6. The presence of significantly more neurological soft signs in OCD patients compared with healthy control subjects.[31]

5) Course and Prognosis

Recent studies indicate that 24%-33% of patients have a fluctuating course, 11%-14% have a phase course with periods of complete remission, and 54%-61% have a constant or progressive course. Although prognosis of OCD has traditionally been considered to

be poor, developments in behavioural and pharmacological treatments have improved prognosis considerably. Depression and anxiety are common complications of OCD.[32]

6) Differential Diagnosis[33]

In Common with	Characteristics Shared	Exclusively characteristic of Obsessive-Compulsive Disorder or of the disorder with which it is compared or difference between the two disorders
Anxiety Disorder Due to a General Medical Condition	Obsession or compulsion	Obsession or compulsion is a direct physiological consequence of a specific general medical condition
Substance-Induced Anxiety Disorder	Obsession or compulsion	A substance (i.e., a drug of abuse, a medication, or exposure to a toxin) is etiologically related to the obsessions or compulsions
Body Dysmorphic Disorder, Specific Phobia, Social Phobia, Trichotillomania	Recurrent or intrusive thoughts, impulses, images, or behaviours	The content of the thoughts or the activities are exclusively related to these mental disorders and not to obsessive-compulsive disorder.
Major Depressive Episode	Persistent brooding about potentially unpleasant circumstances	These symptoms are mood-congruent aspect of depression rather than an obsession
Generalized Anxiety Disorder	Excessive worry	Generalized anxiety disorder – the patient experiences the worry as excessive concerns about real-life circumstances; Obsessive-compulsive disorder – the content of obsession is not typically real-life problems, and the obsession is experienced as inappropriate by the individual
Schizophrenia	Ruminative delusional thoughts and bizarre stereotyped behaviours	Unlike in obsessive-compulsive disorder the symptoms are ego-dystonic.
Eating Disorders, Paraphilias, Pathological Gambling, Alcohol Dependence or Abuse	"Compulsive"	The symptoms are not strictly speaking compulsive since the patients usually derive pleasure from the activity and may wish to resist it only because of its deleterious consequences
Obsessive-Compulsive Personality Disorder	Similar names	Obsessive-compulsive personality disorder does not have obsession or compulsion but has a pervasive pattern of preoccupation with orderliness, perfectionism
Superstitions and Repetitive Checking Behaviours	"Apparent compulsion"	They are commonly encountered in everyday life and will become compulsion only when they are time consuming, or result in clinically significant impairment or distress

7) Treatment

What was previously thought to be a rare, psychodynamically laden, and difficult-to-treat illness now appears to have a strong biological component and to respond well to potent serotonin reuptake inhibitors.

1) Behaviour Therapy

Behavioural treatments of OCD involve two separate components: 1. exposure procedures that aim to decrease the anxiety

associated with obsessions and 2. response prevention techniques that aim to decrease the frequency of ritual or obsessive thoughts. Exposure techniques range from systematic desensitisation with brief imaginal exposure, to flooding, in which prolonged exposure to the real-life ritual-evoking stimuli causes profound discomfort. Exposure techniques aim to ultimately decrease the discomfort associated with the eliciting stimuli through habituation. In exposure therapy, the patient is assigned homework exercises that must be performed and the patient may require assistance in achieving exposure at home through therapists' home visits or from family members.

Response prevention involves having patients face feared stimuli (e.g., dirt, chemicals) without excessive hand washing or having them tolerate doubt (e.g., doubt about whether the door is locked) without excessive checking. Initial work may involve delaying performance of the ritual, but ultimately the patient attempts to resist the compulsions fully. The psychoeducation and support of family members can be pivotal to the success of the behaviour therapy, because family dysfunction is prevalent and the majority of parents or spouses accommodate to or are involved in the patients' rituals, possibly as a way to reduce the anxiety or anger that patients may direct at their family members. It is generally agreed that combined behavioural techniques (i.e., exposure with response prevention) yield the greatest improvement.[34]

2) Cognitive Therapy

Cognitive therapy is a form of therapy that centres on cognitive reformulation of themes related to the perception of danger, estimation of catastrophe, expectations about anxiety and its consequences, excessive responsibility, thought-action fusion, and illogical inferences. The effectiveness of such a therapy is not very definite.[35]

SECTION - III

POSTTRAUMATIC STRESS DISORDER

12. Posttraumatic Stress Disorder (PTSD)

(DSM-IV Code: 309.81 & ICD-10 Code: F43.1)

Posttraumatic stress disorder (PTSD) was first introduced in DSM-III, its inclusion being spurred in part by the increasing recognition of posttraumatic conditions in veterans of the Vietnam War. As in DSM-III-R, the disorder continues to be classified with the anxiety disorders, and the major criteria of an extreme precipitating stressor, intrusive recollections, emotional numbing, and hyperarousal have been maintained.

Not all agree that PTSD belongs with the anxiety disorders. Although anxiety is a prominent symptoms, depression and dissociation are prominent symptoms as well. The diagnostic criterion of a precipitating stressor or trauma in PTSD makes this disorder different from other anxiety disorders and is more reminiscent of conditions such as brief reactive psychosis, acute stress disorder, pathological bereavement, and adjustment disorders. The International Classification of Diseases, 10th Revision (ICD-10; World Health Organization 1992), classifies all such disorders as stress related.

Beyond the symptoms of PTSD per se, increasing attention has been drawn to an enduring constellation of traits that frequently develop in individuals subjected to chronic trauma as children or adults. Investigators such as Herman and van der Kolk have suggested that a discrete entity of complicated posttraumatic syndromes be recognized, otherwise designated as DESNOS (disorders of extreme stress not otherwise specified), characterized by lasting changes in identity, interpersonal relationships, and the sense of life's meaning. Similar personality changes are recognized by ICD-10 and classified as 'enduring personality change after catastrophic experience.'

1) Diagnostic Criteria[36]

A person participates in the torture and murder of innocent children. A passenger is the sole survivor of a bus that plunges

into a deep pit. A girl is raped and is beaten severely by an unknown assailant. The characteristic features that may develop after such traumatic events are psychic numbing, reexperiencing of the trauma, and increased autonomic arousal. The trauma is reexperienced in recurrent painful, intrusive recollections, daydreams, or nightmares. Dissociative states may occur, lasting from minutes to days, in which there is an actual reliving of the event. Psychic numbing or emotional anesthesia is manifested by diminished responsiveness to the external world, involving feelings of being detached from other people, loss of interest in usual activities, and inability to feel emotions such as intimacy, tenderness, or sexual interest. Symptoms of excessive autonomic arousal may include hyperactivity and irritability, an exaggerated startle response, difficulty concentrating, and sleep abnormalities. Rape or mugging victims sometimes become afraid to venture out alone for variable periods. Situations reminiscent of the original trauma may be systematically avoided.

There may be other symptoms like guilt about having survived, guilt about not having prevented the traumatic experience, depression, anxiety, panic attacks, shame, and rage. There may be prolonged episodes of intense affect; increased irritability, explosive, hostile behaviour; and impulsive behaviour. Still other accompanying symptoms include substance abuse, self-injurious behaviour and suicide attempts, occupational impairment, and interference with interpersonal relationships.

Diagnostic Criteria for Posttraumatic Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behaviour

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

   (1) recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
   (2) Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
   (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). In young children trauma-specific reenactment may occur.
   (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
   (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
   (1) efforts to avoid thoughts, feelings, or conversations associated with the trauma
   (2) efforts to avoid activities, places, or people that arouse recollections of the trauma
   (3) inability to recall an important aspect of the trauma
   (4) markedly diminished interest or participation in significant activities
   (5) feeling of detachment or estrangement from others
   (6) restricted range of affect (e.g., unable to have loving feelings)
   (7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
   (1) difficulty falling or staying asleep
   (2) irritability or outbursts of anger
   (3) difficulty concentrating

(4) hypervigilance

(5) exaggerated startle response

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

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

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

2) Aetiology

(1) Role of the stressor

The severity of the stressor in PTSD differs in magnitude from that in adjustment disorder; in adjustment disorder the stressor is usually less severe and within the range of common life experience. However, this relationship between the severity of the stressor and the type of subsequent symptomatology is not always predictable. Nevertheless, events such as rape and burglary, which are insults to personal integrity, self-esteem, and security are particularly likely to lead to PTSD. When stressors become extreme (e.g., rape, extended combat, torture, or concentration camp experiences), the rate of morbidity increases markedly.[37]

(2) Premorbid Predictors

There is some disagreement concerning whether premorbid factors predispose to the development of PTSD. Although the disorder can develop in people who do not have much preexisting psychopathology, some studies suggest that predisposing psychological factors or adverse childhood experiences may render individuals more vulnerable to the development of PTSD.

(3) Biological Theories

Janet, more than a century ago, described the breakdown in normal adaptation, information processing, and action that can result from overwhelming trauma and noted the automatic emotional and physical overreaction that occurs with reexposure. Freud implicated a biological basis to posttraumatic symptoms, in the form of a physical fixation to the trauma. Pavlov demonstrated chronic change in autonomic nervous system activity level in response to repeated traumatic exposure. Kardiner (1959) comprehensively described the phenomenology of war traumatic neurosis, identifying five cardinal features: 1. persistence of startle response, 2. fixation on the trauma, 3. atypical dream life, 4. explosive outbursts, and 5. overall constriction of personality.

3) Course and Prognosis

Scrignar (1984) divided the clinical course of PTSD into three stages. Stage 1 involves the response to trauma. Nonsusceptible persons may experience an adrenergic surge of symptoms immediately after the trauma but do not dwell on the incident. Predisposed persons have higher levels of anxiety at baseline, an exaggerated response to the trauma, and an obsessive preoccupation with the trauma after the trauma has occurred. If the symptoms persist beyond 4-6 weeks, the patient enters stage 2, or acute PTSD. Feelings of helplessness and loss of control, symptoms of increased autonomic arousal, reliving of the trauma, and somatic symptoms may occur. Life becomes centred around the trauma and there are changes in lifestyle, personality, and social functioning. Phobic avoidance, startle responses, and angry outbursts may occur. In stage 3, chronic PTSD develops, in which the patient experiences disability, demoralization, and despondency. The patient's emphasis changes from preoccupation with the actual trauma to preoccupation with the physical disability resulting from the trauma.[38]

4) Differential Diagnosis[39]

In Common with	Characteristics Shared	Exclusively characteristic of Posttraumatic Stress Disorder or of the disorder with which it is compared or the difference between the two disorders
Adjustment Disorder	Stressor	In PTSD the stressor must be of an extreme (life-threatening) nature unlike in adjustment disorder in which the stressor can be of any severity

Acute Stress Disorder	Similar symptom	The symptom pattern in acute stress disorder must occur within 4 weeks of the traumatic event and resolve within that 4-week period. If the symptoms persist more than a month, then it is PTSD.
Obsessive-Compulsive Disorder	Recurrent intrusive thoughts	Unlike in PTSD, the recurrent intrusive thoughts are experienced as inappropriate
Schizophrenia, other Psychotic Disorders, Mood Disorder With Psychotic Features, Delirium, Substance-Induced Disorders, Psychotic Disorders Due to a General Medical Condition	'Illusions' and 'hallucinations'	In PTSD they are flashbacks and not illusions and hallucinations in the proper sense as we find them in psychotic problems

5) Treatment

(1) Pharmacotherapy

A variety of different psychopharmacological agents have been used in the treatment of PTSD by clinicians and reported in the literature as case reports, open clinical trials, and controlled studies. Thus Adrenergic blockers, Tricyclics, Monoamine oxidase inhibitors, Lithium, Anticonvulsants, Serotonin reuptake inhibitors and Buspirone are used.[40]

(2) Psychotherapy[41]

It is generally believed that some form of psychotherapy is necessary in the treatment of posttraumatic pathology. Crisis intervention shortly after the traumatic event is effective in reducing immediate distress, possibly prevents chronic or delayed responses, and, if the pathological response is still tentative, may allow for briefer interventions.

Brief dynamic psychotherapy has been advocated both as an immediate treatment procedure and as a way of preventing chronic disorder. Embry (1990) outlined seven major parameters for effective psychotherapy in war veterans with chronic PTSD: 1. initial rapport building, 2. limit setting and supportive confrontation, 3. affective modelling, 4. defocusing on stress and focusing on current life events, 5. sensitivity to transference-countertransference issues, 6. understanding of secondary gain, and 7. therapist's maintenance of a positive treatment attitude. Group therapy can also serve as an adjunctive treatment, or as the central treatment mode. The identification, support, and hopefulness of peer settings can facilitate therapeutic change.

Behaviour Therapy

A variety of behavioural techniques have been applied. People involved in traumatic events such as accidents frequently develop phobias or phobic anxiety related to or associated with these situations. Systematic desensitisation or graded exposure has been found to be effective in cases of phobia or phobic anxiety associated with PTSD. This technique is based on the principle that when patients are gradually exposed to a phobic or anxiety-provoking stimulus, they will become habituated or deconditioned to the stimulus. Variations of this treatment include using imaginal techniques (i.e., imaginal desensitisation) and exposure to real-life situation (i.e., in vivo desensitisation). Prolonged exposure (i.e., flooding), if tolerated by patients, can be useful and has been reported to be successful.

Relaxation techniques produce the beneficial physiological result of reducing motor tension and lowering the activity of the autonomic nervous system. Progressive muscle relaxation involves contracting and relaxing various muscle groups to introduce the relaxation response. This technique is useful for symptoms of au-

tonomic arousal such as somatic symptoms, anxiety, and insomnia. Hypnosis has also been used to induce the relaxation response.

Cognitive therapy and thought stopping have been used to treat unwanted mental activity in PTSD.

SECTION - IV

ACUTE STRESS DISORDER

13. Acute Stress Disorder

(DSM-IV Code: 308.3 & ICD-10 Code: F43.0)

The essential feature of Acute Stress Disorder is the development of characteristic anxiety, dissociative, and other symptoms that occurs within 1 month after exposure to an extreme traumatic stressor.

1) Diagnostic Criteria[42]

Diagnostic Criteria for Acute Stress Disorder

A. The person has been exposed to a traumatic event in which both of the following were present:
   (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
   (2) the person's response involved intense fear, helplessness, or horror

B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
   (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness
   (2) reduction in awareness of his or her surroundings (e.g., 'being in a daze')
   (3) derealization
   (4) depersonalisation

   (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.

D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).

E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.

H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

2) Course

Symptoms of Acute Stress Disorder are experienced during or immediately after the trauma, last for at least 2 days, and either resolve within 4 weeks after the conclusion of the traumatic event or the diagnosis is changed. When symptoms persist beyond 1 month, a diagnosis of Posttraumatic Stress Disorder may be appropriate if the full criteria for Posttraumatic Stress Disorder are met. The severity, duration, and proximity of an individual's exposure to the traumatic event are the most important factors in determining the likelihood of development of Acute Stress Disorder. There is some evidence that social supports, family history, childhood experiences, personality variables, and preexisting mental

disorders may influence the development of Acute Stress Disorder. This disorder can develop in individuals without any predisposing conditions, particularly if the stressor is especially extreme.

3) Differential Diagnosis[43]

In Common with	Characteristics Shared	Exclusively characteristic of Acute Stress Disorder or of the disorder with which it is compared or difference between the two disorders
Mental Disorder Due to a General Medical Condition	Similar symptoms	Here the cause is a general medical condition
Substance-Induced Disorder	Similar symptoms	Here the cause is a substance
Posttraumatic Stress Disorder	Similar symptoms	PTSD requires more than 1 month of symptoms
Brief Psychotic Disorder	Similar symptoms	Unlike Acute Stress disorder, Brief Psychotic Disorder has psychotic symptoms
Adjustment Disorder	Extreme stressor	If symptoms pattern does not meet the criteria for Acute Stress Disor der, then it is Adjustment Disorder

SECTION - V

GENERALIZED ANXIETY DISORDER

14. Generalized Anxiety Disorder (Includes the Overanxious Disorder of Childhood)

(DSM-IV Code: 300.02 & ICD-10 Code: F41.1)

Generalized anxiety disorder (GAD) is the main diagnostic category for prominent and chronic anxiety in the absence of panic disorder. The essential feature of this syndrome is persistent anxiety lasting at least 6 months. The symptoms of this type of anxiety fall within two broad categories: apprehensive expectation and physical symptoms.

Patients with GAD are constantly worried over trivial matters, fearful, and anticipating the worst. Muscle tension, restlessness, feeling keyed up (hypervigilance), difficulty concentrating, insomnia, irritability, and fatigue are symptoms for GAD. Motor tension and hypervigilance better differentiate GAD from anxiety states than does autonomic hyperactivity.[44]

1) Differential Diagnosis[45]

In Common with	Characteristics Shared	Exclusively characteristic of Generalized Anxiety Disorder or of the disorder with which it is compared or difference between the two disorders
Mental Disorder Due to a General Medical Condition	Anxiety	Here the cause is a general medical condition
Substance-Induced Disorder	Anxiety	Here the cause is a substance
Posttraumatic Stress Disorder	Anxiety	The anxiety occurs exclusively during the course of PTSD
Obsessional Thoughts	Excessive worry	Obsessional thoughts are ego-dystonic intrusions that often take the form of urges, impulses, and images in addition to thoughts
Adjustment Disorder	Anxiety	In adjustment disorder anxiety occurs in response to a life stressor and does not persist for more than 6 months after the termination of the stressor

SECTION - VI

ETIOLOGOY

15. Aetiology

1) Biological Theories[46]

A number of biological theories of both panic disorder and, to a much lesser extent, GAD are prominent in the psychiatric literature.

Biological Theories of Panic Disorder and to a Much Less Extent GAD	
Catecholamine theory	Massive b–adrenergic nervous system discharge
Locus coeruleus theory	Increased discharge of central nervous system noradrenergic nuclei
Metabolic theory	Aberrant metabolic changes induced by lactate infusion
False suffocation alarm theory	Hypersensitive brain-stem carbondioxide receptors
y-Aminobutyric acid (GABA)-benzodiazepine theory	Abnormal receptor function leading to decreased inhibitory activity
Genetic theory	Attempts to isolate a panic gene from family pedigree (without positive results to date)
Neuroethological theory	Biologically disrupted innate attachment mechanism

2) Psychodynamic Theories

Here we shall see the major landmarks in the evolution of psychodynamic theories of anxiety and panic, along with their relationship to recent biological advances.

Freud's first theory of anxiety neurosis (id or impulse anxiety)

In his earliest concept of anxiety formation, Freud (1895) postulated that anxiety stems from the direct physiological transformation of libidinal energy into the somatic symptoms of anxiety, without the mediation of psychic mechanisms. For this the evidence he found was in the sexual practices and experiences of patients with anxiety, which were characterized by disturbed sexual arousal and continence and coitus interruptus. He termed such anxiety an 'actual neurosis,' as opposed to a psychoneurosis, because of the postulated absence of psychic processes. Such anxiety, originating from overwhelming instinctual urges is referred as 'id' or 'impulse anxiety.' Though Freud started to modify his theory, the basic tenet that anxiety stemmed from undischarged sexual energy remained the same. According to the topographic theory of Freud, anxiety resulted from forbidden sexual drives in the unconscious being repressed by the preconscious.[47]

3) Structural Theory and Intrapsychic Conflict

By 1926, with the proposal of the structural theory of the mind, Freud's theory of anxiety had undergone a major transformation. Anxiety is an affect belonging to the ego and acts as a signal alerting the ego to internal danger. The danger stems from intrapsychic conflict between instinctual drives from the id, superego prohibitions, and external reality demands. Anxiety acts as a signal to the ego for the mobilization of repression and other defences to counteract the threat to intrapsychic equilibrium. Inhibitions and neurotic symptoms develop as measures designed to avoid the dangerous situation and to allow only partial gratification of instinctual wishes, thus warding off signal anxiety. In this revised theory then, anxiety leads to repression, instead of the reverse.

The intrapsychic conflict model of anxiety continues to constitute a major tenet of contemporary psychoanalytic theory. Though psychoanalytic theories are not universally accepted by psychiatrists today, they are tools to understand and treat at least some patients. Freud maintained that biological predispositions to psychiatric symptoms are undoubtedly operant in most conditions and that constitutional factors could play a role in the particular form that neurotic symptoms take in different patients.[48]

4) Separation Anxiety

In 1964, D.F. Klein advanced an etiological theory that agoraphobia with panic attacks represents an aberrant function of the biological substrate that underlies normal human separation anxiety. He advanced the notion based on attachment and separation, that the attachment of an infant animal or human to its mother is not simply a learned response but is genetically programmed and biologically determined. The initial panic attack in the history of a patient who goes on to develop panic disorder is sometimes preceded by the real or threatened loss of a significant relationship.[49]

5) Learning Theories

Behaviour or learning theorists hold that anxiety is conditioned by the fear of certain environmental stimuli. If every time a laboratory animal presses a bar it receives a noxious electric shock, the pressing of the lever becomes a conditioned stimulus that precedes the unconditioned stimulus (i.e., the shock). The conditioned stimulus releases a conditioned response in the animal, namely anxiety, which leads the animal to avoid contact with the lever, thereby avoiding the shock. Successful avoidance of the unconditioned stimulus, namely the shock, reinforces the avoidant behaviour. This leads to a decrease in anxiety level.

In the same way we might say that anxiety attacks are conditioned responses to fearful situations. For example, an infant learns that if its mother is not present (i.e., the conditioned stimulus) it will experience hunger (i.e., the unconditioned stimulus) and learns to become anxious automatically whenever the mother is absent (i.e., the conditioned response). The anxiety may persist even after the child is old enough to feed itself. But the problem is in many patients no such traumatic event can ever be paired with the onset of panic disorder. For example in patients with GAD, no precipitating event that works as unconditioned stimulus can be found out.[50]

SECTION-VII

INDUCED ANXIETY DISORDER

16. Anxiety Disorder Due to a General Medical Condition

(DSM-IV Code: 293.89 & ICD-10 Code: F06.4)

Diagnostic Criteria[51]

The essential feature of Anxiety Disorder Due to a General Medical Condition is clinically significant anxiety that is judged to be due to the direct physiological effects of a general medical condition. Symptoms can include prominent, generalized anxiety symptoms, panic attacks, or obsessions or compulsions.

Diagnostic Criteria for Anxiety Disorder Due to the General Medical Condition

A. Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct physiological consequence of a general medical condition

C. The disturbance is not better accounted for by another mental disorder (e.g., Adjustment Disorder With Anxiety in which the stressor is a serious general medical condition).

D. The disturbance does not occur exclusively during the course of a delirium.

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

Specify if:

With Generalized Anxiety: if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation or With Panic Attacks: if Panic Attacks predominate in the clinical presentation or With Obsessive-Compulsive Symptoms: if obsessions or compulsions predominate in the clinical presentation

Code note: Include the name of the general medical condition on Axis I, e.g., 293.89 Anxiety Disorder due to Pheochromocytoma, With Generalized Anxiety; also code the general medical condition on Axis III.

17. Substance-Induced Anxiety Disorder

Diagnostic Criteria[52]

The essential features of Substance-Induced Anxiety Disorder are prominent anxiety symptoms that are judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or toxin exposure)

Diagnostic Criteria for Substance-Induced Anxiety Disorder

A. Prominent anxiety, Panic Attacks, or obsessions or compulsions predominate in the clinical picture.

B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2):

   (1) the symptoms in Criterion A developed during, or within 1 month of, Substance Intoxication or Withdrawal

   (2) medication use is etiologically related to the disturbance

C. The disturbance is not better accounted for by an Anxiety Disorder that is not substance induced. Evidence that the symptoms are better accounted for by an Anxiety Disorder that is not substance induced might include the following: the symptoms precede the onset of the substance use (or medication use); the symptoms persist for a substantial period of time (e.g., about a month) after the cessation of acute withdrawal or severe intoxication or are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use; or there is other evidence suggesting the existence of an independent non-substance-induced Anxiety Disorder (e.g., a history of recurrent non-substance-related episodes).

D. The disturbance does not occur exclusively during the course of a delirium.

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

Note: This diagnosis should be made instead of a diagnosis of Substance Intoxication or Substance Withdrawal only when the anxiety symptoms are in excess of those usually associated with the intoxication or withdrawal syndrome and when the anxiety symptoms are sufficiently severe to warrant independent clinical attention.

Code (Specific Substance)-Induced Anxiety Disorder

(291.8 Alcohol; 292.89 Amphetamine (or Amphetamine-Like Substance); 292.89 Caffeine; 292.89 Cannabis; 292.89 Cocaine; 292.89 Hallucinogen; 292.89 Inhalant; 292.89 Phencyclidine (or Phencyclidine-Like Substance); 292.89 Sedative, Hypnotic, or Anxiolytic; 292.89 Other [or Unknown] Substance)

Specify if:

With Generalized Anxiety: if excessive anxiety or worry about a number of events or activities predominates in the clinical presentation or With Panic Attacks: if Panic Attacks predominate in the clinical presentation or With Obsessive-Compulsive Symptoms: if obsessions or compulsions predominate in the clinical presentation or With Phobic Symptoms: if phobic symptoms predominate in the clinical presentation

Specify if:

With Onset During Intoxication: if the criteria are met for Intoxication with the substance and the symptoms develop during the intoxication syndrome or With Onset During Withdrawal: if criteria are met for Withdrawal from the substance and the symptoms develop during, or shortly after, a withdrawal syndrome

18. Anxiety Disorder Not Otherwise Specified[53]

(DSM-IV Code: 300.00 & ICD-10 Code: F41.9)

Anxiety Disorder Not Otherwise Specified

This category includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific Anxiety Disorder, Adjustment Disorder With Anxiety or Adjustment Disorder With Mixed Anxiety and Depressed Mood. Examples include

1. Mixed anxiety-depressive disorder: clinically significant symptoms of anxiety and depression, but the criteria are not met for either a specific Mood Disorder or a specific Anxiety Disorder
2. Clinically significant social phobic symptoms that are related to the social impact of having a general medical condition or mental disorder (e.g., Parkinson's disease, dermatological conditions, Stuttering, Anorexia Nervosa, Body Dysmorphic Disorder)
3. Situations in which the clinician has concluded that an Anxiety Disorder is present but is unable to determine whether it is primary, due to a general medical condition, or substance induced

19. Conclusion

Anxiety disorders with their various forms are a challenge to mental health. Some of the forms are amenable to medication and psychotherapies. Some of them are stubborn and unyielding for example Obsessive-Compulsive Disorders. In certain cases of anxiety disorders their comorbidity can be treated and thus indirectly anxiety disorders. A psychotherapist needs to know what types of therapies apply to what forms of anxiety disorders in order to be effective in counselling individuals with anxiety disorders.

20. Decision Tree for Differential Diagnosis[54]

Differential Diagnosis of Anxiety Disorders

Symptoms of anxiety, fear, voidance, or increased arousal.

1. Are they due to the direct physiological effects of a general medical condition?

   If yes, then it is Anxiety Disorder Due to a General Medical Condition.

2. If no to the 1st question, are they due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, a toxin)?

   If yes, then it is Substance-Induced Anxiety Disorder.

3. If no to the 2nd question, are there recurrent unexpected Panic Attacks plus a month of worry, concern about attacks, or change in behaviour?

   If yes, is there Agoraphobia, i.e., anxiety about being in places from which escape might be difficult or embarrassing in the event of having a Panic Attack?

   If yes, then it is Panic Disorder With Agoraphobia.

   If no, then it is Panic Disorder Without Agoraphobia.

4. If no to the 3rd question, is there Agoraphobia, i.e., anxiety about being in places from which escape might be difficult or embarrassing in the event of having panic-like symptoms?

   If yes, then it is Agoraphobia Without History of Panic Disorder.

5. If no to the 4th question, is there anxiety concerning separation from attachment figures with onset in childhood?

   If yes, then it is Separation Anxiety Disorder.

6. If no to the 5th question, is there fear of humiliation or embarrassment in social or performance situations?

   If yes, then it is Social Phobia (Social Anxiety Disorder)

7. If no to the 6th question, is there fear cued by object or situation?

   If yes, then it is Specific Phobia.

8. If no to the 7th question, are there obsessions or compulsions?

   If yes, then it is Obsessive-Compulsive Disorder.

9. If no to the 8th question, is there a 6-month period of excessive anxiety and worry plus associated symptoms?

   If yes, does it occur exclusively during a Mood or Psychotic Disorder?

   If no, then it is Generalized Anxiety Disorder.

   If yes, then see Mood Disorders or Psychotic Disorders tree.

10. If no to the 9th question, is there anxiety in response to a severe traumatic event?

    If yes, is there experiencing of event, increased arousal, and avoidance of stimuli associated with traumatic event?

    If yes, is there a duration of more than 1 month.

    If yes, then it is Posttraumatic Stress Disorder.

    If no, then it is Acute Stress Disorder.

11. If no to the 10th question, is there anxiety that does not meet criteria for one of the above Anxiety Disorders and develops in response to a stressor?

    If yes, then it is Adjustment Disorder With Anxiety.

12. If no to the 11th question, are there clinically significant symptoms that do not meet criteria for a specific Anxiety Disorder?

    If yes, then it is Anxiety Disorder NOS.

13. If no to the 12th question, then there is No Anxiety Disorder (symptoms of fear, anxiety, or avoidance that are not clinically significant)

5
DISSOCIATIVE DISORDERS

1. Introduction

The essential feature of the dissociative disorder is a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment. The disturbance may be sudden or gradual, transient or chronic.

The dissociative disorders involve a disturbance in the integrated organization of identity, memory, perception, or consciousness. Events normally experienced on a smooth continuum are isolated from the other mental processes with which they would ordinarily be associated. This isolation results in a variety of dissociative disorders depending on the primary cognitive process affected. When memories are poorly integrated, the resulting disorder is 'dissociative amnesia.' Fragmentation of identity results in 'dissociative fugue' or 'dissociative identity disorder' (DID), which was formerly known as 'multiple personality disorder' or MPD. Disordered perception yields 'depersonalisation disorder.' Dissociation of aspects of consciousness produces 'acute stress disorder' and various dissociative trance and possession states.

These dissociative disorders are more a disturbance in the organization or structure of mental contents than in the contents themselves. For example, memories in dissociative amnesia are not so much distorted or bizarre as they are segregated from one another. The identity temporarily lost in dissociative fugue, or the aspects of the self that are fragmented in DID, are two-dimensional aspects of an overall personality structure. In this sense, it has been said that patients with DID suffer not from having more than one personality, but rather from having less than one personality. The problem is the failure of integration rather than the contents of the fragments. Thus all types of dissociative disorders have in common a lack of immediate access to the entire personality structure or mental content in one form or another.

A cross-cultural perspective is particularly important in the evaluation of Dissociative Disorder because dissociative states are a common and accepted expression of cultural activities or religious experience in many societies.

The dissociative disorders remain an area of psychopathology for which the best treatment is psychotherapy. The dissociative disorders were included in DSM-III (1980) and its revised edition, DSM-III-R (1987), and have been retained with some changes in nomenclature and diagnostic criteria in DSM-IV (1994).[1]

2. Development of the Concept

Jean Martin Charcot (1890), a well-known French neurologist, became interested in the dissociated-like features experienced by some of his patients who had unusual neurological-like symptoms. He discovered that hypnosis could reproduce and reverse some of the deficits manifested by his patients. The French physician and psychologist Pierre Janet (1920) is credited with the initial description of dissociation as a disorder. He described hysteria as a 'malady of the personal synthesis.' He viewed dissociation as a purely pathological process. Dissociative disorders could not be studied in depth since Janet's and Charcot's work were eclipsed by the psychoanalytic approach pioneered by Freud. Freud learned hypnosis from Charcot. Freud and Breuer began an exploration of dissociative phenomena. However both of them formulated the role of the capacity to dissociate through the concept of 'hypnotic states' rather than the mechanism of dissociation. They thought that dissociative symptoms should be attributed to the capacity to enter these hypnoid states rather than the reverse. Freud went on to study other kinds of patients, such as those with 'obsessive-compulsive neurosis' and schizophrenia. Freud's interest began to wane in dissociation as a defence and started to have increasing interest in repression as a more general model for motivated forgetting in unconscious process.

Hilgard (1977) developed a neodissociation theory designed to revive interest in Janetian psychology and psychopathology. He postulated a mental structure with divisions that were horizontal rather than vertical, as in Freud's archaeological model. Unlike Freud's system, Hilgard's model would allow for immediate access to consciousness of any of a variety of warded-off memories. In

the dynamic unconscious model, repressed memories must first go through a process of transformation as they are accessed and lifted from the depths of the unconscious. In Hilgard's model, amnesia is a crucial mediating mechanism that provides the barriers that divide one set of mental contents from another. Thus, the flexible and reversible use of amnesia is a key defensive tool, whereas the reversal of amnesia is an important therapeutic tool.[2]

Repression as a general model for keeping information out of conscious awareness differs from dissociation in six important ways.

1. The organizational structure of mental contents in dissociation is horizontal, with subunits of information divided from one another but equally available to consciousness. Repressed information, on the other hand, is presumed to be stored in an archaeological manner, at various depths, and therefore different parts are not equally accessible.
2. Subunits of information are presumed to be divided by amnestic barriers in dissociation, whereas dynamic conflict, motivated forgetting, is the mechanism underlying repression.
3. Information kept out of awareness in dissociation is often for a discrete and sharply delimited period of time, usually for a traumatic experience, whereas repressed information may be for a variety of experiences, fears, or wishes scattered across time. Dissociation seems to be elicited as a defence especially after episodes of physical trauma, whereas repression is a response to warded-off fears and wishes or in response to other dynamic conflicts.
4. Dissociated information is stored in a discrete and untransformed manner, whereas repressed information is usually disguised and fragmented. Even when repressed information becomes available to consciousness, its meaning is hidden (e.g., in dreams, slips of the tongue).
5. Retrieval of dissociated information often can be direct. Techniques such as hypnosis can be used to access warded-off memories. In contrast, uncovering of repressed information often requires repeated recall trials through intense questioning, psychotherapy, or psychoanalysis with subsequent interpretation (i.e., of dreams).
6. The focus of psychotherapy for dissociation is integration, via control of access to dissociated states and working through of traumatic memories. The classical psychotherapy for repression involves interpretation, including working through the transference.

There is debate about whether dissociation is a subtype of repression or vice versa. Such a dispute is probably not resolvable. What has become clear is that the accomplishment of a sense of mental unity is an achievement, not a given.[3]

3. Difference between Dissociation and Repression[4]

Difference between Dissociation and Repression

	Dissociation	Repression
1. Organizational structure	Horizontal	Vertical
2. Barriers	Amnesia	Dynamic conflict
3. Aetiology	Trauma	Developmental conflict over unacceptable wishes
4. Content	Untransformed traumatic memories	Disguised, primary process: dreams, slips of the tongue
5. Means of access	Hypnosis	Interpretation
6. Psychotherapy	Access, control, and working through traumatic memories	Interpretation, transference

4. Models and Mechanisms of Dissociation

1) Dissociation and Information Processing

Modern information processing based theories, including connectionist and parallel distributed processing (PDP) models, take a bottom-up rather than a top-down approach to cognitive organization. Traditional models emphasize a superorganization in which broad categories of information structure the processing of specific examples. In PDP models, it is theoretically likely that failures in integration of mental contents will occur. Indeed, at-

tempts have been made to model psychopathology based on difficulties in neural net information processing, for example, in schizophrenia and bipolar disorder, as well as in dissociative disorders. The idea is that when a net runs into difficulty in balancing the processing of input information (a model for traumatic input), it is more likely to have difficulty achieving a unified and balanced output. Such neural nets tend to fall into a 'dissociated' situation in which they move in one direction or another but cannot reach an optimal balanced solution, and therefore they are unable to process smoothly all of the incoming information.[5]

2) Dissociation and Memory Systems

Modern research on memory demonstrates that there are at least two broad categories of memory, variously described as explicit and implicit or episodic and semantic. These two memory systems serve different functions. Explicit (or episodic) memory involves recall of personal experience identified with the self (e.g., 'I was at the theatre last night'). The other type, implicit (or semantic) memory, involves the execution of routine operations, such as riding a car or typing. Such operations may be carried out with a high degree of proficiency with little conscious awareness of either their current execution or the learning episodes on which the skill is based. These two types of memory may have different anatomical localizations: the limbic system, especially the hippocampal formation, and mamillary bodies for episodic memory, and the basal ganglia and cortex for procedural (or semantic) memory. The distinction between these two types of memory may account for certain dissociative phenomena. The automaticity observed in certain dissociative disorders may be a reflection of the separation of self-identification in certain kinds of explicit memory from routine activity in implicit or semantic memory. Thus it is likely that our mental processing to act in an automatic way devoid of explicit self-identification. There is thus a fundamental model in memory research for the dissociation between identity and performance that may well find its pathological reflection in disorders such as dissociative amnesia, fugue, and identity disorder.[6]

3) Dissociation and Trauma

Now let us explore the link between trauma and dissociation. Trauma can be understood as the experience of being made into an object or a thing, the victim of someone else's rage or of

nature's indifference. It is the ultimate experience of helplessness and loss of control over one's own body. Dissociation may occur especially as a defence during trauma – an attempt to maintain mental control at the very moment when physical control has been lost. When a lady was being raped, she imagined of a pleasant bath she had on a sunny beach as a way of detaching herself from the immediate experience of terror, pain, and helplessness. Such individuals often report seeking comfort from imaginary playmates or imagined protectors or absorbing themselves in some perceptual distraction, such as the pattern of the landscape on the wallpapers. Many rape victims report floating above their bodies, feeling sorry for the person being assaulted beneath them. Children exposed to multiple traumas are more likely to use dissociative defence mechanisms, which include spontaneous trance episodes and amnesia.

Numbing (i.e., loss of responsiveness in the wake of trauma) is a predictor of later posttraumatic stress disorder (PTSD) symptomatology. Research on hostages and survivors of other life-threatening events indicates that more than half have experienced feelings of unreality, automatic movements, lack of emotion, and a sense of detachment. Symptoms of depersonalisation and hyperalertness also frequently occur. Such dissociative experiences, especially numbing, have been found to be rather strong predictors of later PTSD. Physical trauma seems to elicit dissociation or compartmentalization of experience and may often become the matrix for later posttraumatic symptomatology, such as dissociative amnesia for the traumatic episode. More extreme dissociative disorders, such as DID, have been considered as chronic PTSDs. Recollection of trauma tends to have an off-on quality involving either intrusion or avoidance in which victims either intensively relive the trauma as though it were recurring or have difficulty remembering it.[7]

4) Acute Stress Disorder

Although acute stress disorder is classified among the anxiety disorders in DSM-IV, mention should be made of it in the context of dissociative disorder. The diagnostic criteria for this disorder would designate as symptomatic in approximately one-fourth to one-third of individuals exposed to serious trauma. These symptoms are strongly predictive of later development of PTSD.

5. Dissociative Amnesia (Formerly Psychogenic Amenesia)

(DSM-IV Code: 300.12 & ICD-10 Code: F44.0)

The hallmark of this disorder is the inability to recall important personal information, usually of a traumatic or stressful nature, which cannot be explained by ordinary forgetfulness. Dissociative amnesia is considered the most common of all dissociative disorders. Amnesia is a symptom commonly found in a number of other dissociative and anxiety disorders, including acute stress disorder, PTSD, somatization disorder, dissociative fugue, and DID. A higher incidence of dissociative amnesia has been described in the context of war and other natural and man-made disasters. There appears to be a direct relationship between the severity of the exposure to trauma and the incidence of amnesia.

Dissociative amnesia is the classical functional disorder of memory and involves difficulty in retrieving discrete components of episodic memory. However, it does not involve a difficulty in memory storage, as in Wernicke-Korsakoff syndrome. Because the amnesia involves primarily difficulties in retrieval rather than encoding or storage, the memory deficits exhibited are usually reversible. Once the amnesia has cleared, normal memory function is resumed.

Dissociative amnesia has three primary characteristics: 1. The memory loss is episodic. The first-person recollection of certain events is lost rather than knowledge of procedures. 2. The memory loss is for a discrete period of time, ranging from minutes to years. It is not vagueness or inefficient retrieval of memories but rather a dense unavailability of memories that had been clearly available. Unlike in the amnestic disorders, for example, from damage to the medial temporal lobe in surgery or in Wernicke-Korsakoff syndrome, there is usually no difficulty in learning new episodic information. Thus, the amnesia is typically retrograde rather than anterograde, with one or more discrete periods of past information becoming unavailable. However there is a syndrome of continuous difficulty in incorporating new information that mimics organic amnestic syndromes. 3. The memory loss is generally for events of a traumatic or stressful nature.[8]

1) Diagnostic Criteria[9]

Diagnostic Criteria for Dissociative Amnesia

A. The predominant disturbance is one or more episodes of inability to recall important personal information, usually of a traumatic or stressful nature, that is too extensive to be explained by ordinary forgetfulness.

B. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder, Dissociative Fugue, Posttraumatic Stress Disorder, Acute Stress Disorder, or Somatization Disorder and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a neurological or other general medical condition (e.g., Amnestic Disorder Due to Head Trauma).

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Dissociative amnesia is most frequently in the third and fourth decades of life. Usually it involves one episode, but multiple periods of lost memory are not uncommon. Comorbidity with conversion disorder, bulimia, alcohol abuse, and depression is common; histrionic, dependent, and borderline personality disorders occur in a substantial minority of such patients. Dissociative amnesia usually involves discrete boundaries around the period of time unavailable to consciousness. The patients lose the ability to recall what happened during a specific period of time. They demonstrate not vagueness or spotty memory but rather a loss of any episodic memory for a finite period of time. They do not remember that they do not remember. Dissociative amnesia most frequently occurs after an episode of trauma, and the onset may be sudden or gradual. Some individuals do suffer from episodes of selective amnesia, usually for specific traumatic incidents, which may be more interwoven with periods of intact memory. In these cases, the amnesia is for a type of material remembered rather than for a discrete period of time.

Despite the fact that certain information is kept out of consciousness in dissociative amnesia, such information may exert an influence on consciousness. For example, a rape victim with no conscious recollection of the assault will nonetheless behave like

someone who has been sexually victimized. It is the essence of dissociative amnesia that material being kept out of conscious awareness is nonetheless active and may influence consciousness indirectly: out of sight does not mean out of mind. Individuals with dissociative amnesia generally do not suffer disturbances of identity, except to the extent that their identity is influenced by the warded-off memory. It is not uncommon for such individuals to develop depressive symptoms as well, especially when the amnesia is in the wake of a traumatic episode.[10]

2) Differential Diagnosis[11]

In Common with	Characteristics Shared	Exclusively characteristic of Dissociative Amnesia or of the disorder with which it is compared or difference between the two disorders
Amnestic Disorder Due to a General Medical Condition	Amnesia	Here amnesia is due to the direct physiological consequence of a specific neurological or other general medical condition (e.g., head trauma, epilepsy)
Amnestic Disorder Due to a Brain Injury	Disturbance to recall	Here the disturbance to recall is retrograde (encompassing a period of time before the head trauma) but in Dissociative Amnesia, the disturbance to recall is almost always anterograde (i.e., memory loss is restricted to the period after the trauma)
Seizure Disorders	Memory impairment	Here the memory impairment is sudden in onset
Delirium and Dementia	Memory loss	Memory loss here is far more extensive involving cognitive, linguistic, affective, attentional, perceptual, and behavioural disturbances. In Dissociative Amnesia, the memory loss is primarily for autobiographical information and cognitive abilities generally are preserved.

Substance-Induced Persisting Amnestic Disorder	Memory loss	Here the memory loss is related to the direct physiological effects of a substance (e.g., a drug of abuse or a medication)
Substance Intoxication (e.g., 'Blackouts')	Memory loss	Here the memory loss is associated with heavy substance use and the amnesia usually cannot be reversed
Dissociative Fugue or Dissociative Identity Disorder	Memory loss	Here the memory loss occurs exclusively during their courses
Depersonalisation Disorder	Memory loss	Depersonalisation can be an associated feature of Dissociative Amnesia and therefore it should not be diagnosed separately
Posttraumatic Stress Disorder; Acute Stress Disorder; Somatization Disorder	Memory loss	Here the memory loss occurs exclusively during their courses

3) Treatment

There are no established pharmacological treatments except for benzodiazepines treatments, or barbiturates for drug-assisted interviews. Most cases of dissociative amnesia revert spontaneously, especially when the individuals are removed from stressful or threatening situations, when they feel physically and psychologically safe, and/or when they are exposed to cues from the past (i.e., family members).

Most patients are highly hypnotizable on formal testing and therefore are easily able to make use of hypnosis such as age regression. Patients are hypnotized and instructed to experience a time before the onset of the amnesia as though it were the present. Then the patients are reoriented in hypnosis to experience events during

the amnestic time period. Hypnosis can enable such patients to reorient temporarily and therefore access to otherwise dissociated memories. If there is traumatic content in the warded-off memory, patients may abreact (i.e., express strong emotion) as these memories are elicited, and they will need psychotherapeutic help in integrating these memories and the associated affect into consciousness.

There is a technique called 'screen technique' by which such memories can be brought into consciousness while modulating the affective response to them. In this approach, patients are taught, by using hypnosis, to relive the traumatic event as if they were watching it on an imaginary movie or television screen. This technique is often helpful for individuals who are unable to relive the event as if it were occurring in the present tense, either because that process is too emotionally taxing or because they are not sufficiently hypnotizable to be able to engage in hypnotic age regression. This technique also helps dissociate between the psychological and somatic aspects of the memory retrieval. Patients can be put into self-hypnosis and instructed to get their bodies into a state of floating comfort and safety. They are reminded that no matter what they see on the screen their bodies will be safe and comfortable.

The psychotherapy of dissociative amnesia involves assessing the dissociated memories, working through affectively loaded aspects of these memories, and supporting the patient through the process of integrating these memories into consciousness.[12]

6. Dissociative Fugue (Formerly Psychogenic Fugue)

(DSM-IV Code: 300.13 & ICD-10 Code: F44.1)

Dissociative fugue combines failure of integration of certain aspects of personal memory with loss of customary identity and automatisms of motor behaviour. Patients appear 'normal,' usually exhibiting no signs of psychopathology or cognitive deficit. Fugue involves one or more episodes of sudden, unexpected, purposeful travel away from home, coupled with an inability to recall portions or all of one's past, and a loss of identity or the assumption of a new identity. In contrast to patients who have Dissociative Identity Disorder (DID), if patients with dissociative fugue develop a new identity, the old and the new identities do not alternate. The onset is usually sudden, and it frequently occurs after a traumatic experience or bereavement. A single episode is not uncommon, and spontaneous remission of symptoms can occur without treatment. In the majority of cases there is loss of personal identity but no clear assumption of a new identity. Many cases of dissociative fugue remit spontaneously. Hypnosis can be useful in assessing dissociated material.

1) Diagnostic Criteria[13]

Diagnostic Criteria for Dissociative Fugue

A. The predominant disturbance is sudden, unexpected travel away from home or one's customary place of work, with inability to recall one's past.

B. Confusion about personal identity or assumption of a new identity (partial or complete).

C. The disturbance does not occur exclusively during the course of Dissociative Identity Disorder and is not due to the direct physiological effects of a substance (e.g., drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

D. The symptoms cause clinically significant distress or impairment in social, occupational, or otherwise important areas of functioning.

2) Differential Diagnosis[14]

In Common with	Characteristics Shared	Exclusively characteristic of Dissociative Fugue or of the disorder with which it is compared or difference between the two disorders
Direct Physiological Consequence of a Specific General Medical Condition	Wandering and semipurposeful behaviour; amnesia	Here the symptoms appear as a consequence of a specific general medical condition like head injury
Complex Partial Seizures	Wandering and semipurposeful behaviour	In seizures there are aura, motor abnormalities, stereotyped behaviour, perceptual alterations, a

		postictal state and abnormal find - ings on serial EEGs. These are not found in dissociative fugue.
Direct Physiological Effects of a Substance	Similar symptoms	The symptoms are directly caused by a substance
Manic Episode	Wandering, purposeful travel	Here the travel is associated with grandiose ideas and the individuals call attention to themselves by inappropriate behaviour
Schizophrenia	Wandering episodes	The patients of dissociative fugue do not have the associated symptoms of schizophrenia like delusions, and negative symptoms

3) Treatment

Hypnosis can be helpful in accessing the otherwise unavailable components of memory and identity. The approach used is similar to that for dissociative amnesia. Hypnotic age regression can be used as the framework for assessing information available at a previous time. Demonstrating to patients that such information can be made available to consciousness enhances their sense of control over the material and facilitates the therapeutic working through of emotionally laden aspects.

Once reorientation is established and the overt aspects of the fugue have been resolved, it is important to work through interpersonal or intrapsychic issues that underlie the dissociative defences. Patients are often relatively unaware of their reactions to stress because they so effectively can dissociate them. Thus, effective psychotherapy is also anticipatory, helping patients to recognize and modify their tendencies to set aside their own feelings in favour of those of others.

Patients may be helped with a psychotherapeutic approach that facilitates conscious integration of dissociated memories and

motivations for behaviour previously experienced as automatic and unwilled. It is good to address current psychosocial stressors. To the extent that current psychosocial stress triggers the fugue, resolutions of that stress can help resolve the fugue state and reduce the likelihood of recurrence. Highly hypnotizable individuals are prone to these extreme dissociative symptoms. Psychotherapy can be effective in helping such individuals recognize and modify their tendency toward unthinking compliance with others and toward extreme sensitivity to rejection and disapproval.[15]

7. Dissociative Identity Disorder (DID) (Formerly Multiple Personality Disorder)

(DSM-IV Code: 300.14 & ICD-10 Code: F44.81)

There has been a considerable rise in the number of reported DID cases in recent years. Some attribute the increase in reported cases to hypnotic suggestion and misdiagnosis. It is argued that individuals with DID are a group highly hypnotizable and therefore quite suggestible and that misleads the diagnosis. Therefore it calls for caution in diagnosing the disorder.

1) Diagnostic Criteria[16]

Diagnostic Criteria for Dissociative Identity Disorder

A. The presence of two or more distinct identities or personality states (each with its own relatively enduring pattern of perceiving, relating to, and thinking about the environment and self).

B. At least two of these identities or personality states recurrently take control of the person's behaviour.

C. Inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness.

D. The disturbance is not due to the direct physiological effects of a substance (e.g., blackouts or chaotic behaviour during Alcoholic Intoxication) or a general medical condition (e.g., complex partial seizures). Note: In children, the symptoms are not attributable to imaginary playmates or other fantasy play.

2) Differential Diagnosis[17]

In Common with	Characteristics Shared	Exclusively characteristic of Dissociative Identity Disorder or of the disorder with which it is compared or the difference between the two disorders
Direct Physiological Consequence of a Specific General Medical Condition	Dissociative symptoms	Here the symptoms appear as a consequence of a specific general medical condition like head injury
Dissociative Symptoms Due to Complex Partial Seizures	Dissociative symptoms	Although these two disorders may co-occur, seizure episodes are generally brief (30 seconds to 5 minutes) and do not involve the complex and enduring structures of identity and behaviour typically found in Dissociative Identity Disorder
Direct Physiological Effects of a Substance	Dissociative symptoms	The symptoms are directly caused by a substance
Those With Trance and Possession Trance Symptoms	Dissociative symptoms	Here, unlike in Dissociative Identity Disorder, they describe external spirits or entities that have entered their bodies and taken control

3) Course

DID is diagnosed in childhood with increasing frequency but typically emerges between adolescence and the third decade of life; it rarely presents as a new disorder after the individual reaches age 40 years. Untreated it is a chronic and recurrent disorder. It rarely remits spontaneously, but the symptoms may not be evident for some time. DID has been called 'a pathology of hiddenness.' The

dissociation itself hampers self-monitoring and accurate reporting of symptoms. Many patients are not aware of the extent of the dissociative symptomatology. They may be reluctant to bring up symptoms because of having encountered frequent scepticism. Furthermore, because the majority of DID patients report histories of sexual and physical abuse, shame associated with that experience as well as fear of retribution, may inhibit reporting of symptoms.

4) Comorbidity

The major comorbid psychiatric illnesses of DID are the depressive disorder, substance disorders and borderline personality disorder. Sexual, eating, and sleep disorders occur less commonly. Patients frequently display self-mutilative behaviour, impulsiveness, and overvaluing and devaluing of relationships. Approximately a third of DID patients fit the criteria for borderline personality disorder as well. Some individuals report somatic or conversion symptoms.[18]

5) Treatment

(1) Psychotherapy

a. Therapeutic Direction

The fundamental psychotherapeutic stance should involve meeting patients halfway in the sense of acknowledging that they experience themselves as fragmented, yet the reality is that the fundamental problem is a failure of integration of disparate memories and aspects of the self. Therefore, the goal in therapy is to facilitate integration of disparate elements. This can be achieved in a variety of ways.

Secrets are frequently a problem with the patients who attempt to use the therapist to reinforce a dissociative strategy that withholds relevant information from certain personality states. Such patients often like to confide plans or stories in the therapist with the idea that the information is to be kept from other parts of the self. It is wise to clarify explicitly that the therapist will not become involved in secret collusion. For example, if a patient's new alter wants to arrange for an apparently accidental death, the therapist should inform the patient that he has to share this information with the other personalities.

b. Hypnosis

First of all, the simple structure of hypnotic induction may elicit dissociative phenomena. The capacity to elicit such symptoms on command provides the first hint of the ability to control these symptoms. Most of these patients have the experience of being unable to stop dissociative symptoms but are often intrigued by the possibility of starting them. This carries with it the potential for changing or stopping the symptoms as well.

Hypnosis can be helpful in facilitating access to dissociated personalities. The personalities simply occur spontaneously during hypnotic induction. An alternative strategy is to hypnotize the patient and use age regression to help him/her reorient to a time when a different personality state was manifest. An instruction later to change times back to the present tense usually elicits a return to the other personality state. This then becomes an alternative means of teaching the patient control over the dissociation.

Alternatively, entering the state of hypnosis may make it possible to simply 'call up' different identities or personality states. Patients can be taught a simple self-hypnosis exercise. Patients can be taught to count to himself/herself from one to three: On 1, do one thing; look up. On 2, do two things: slowly close your eyes and take a deep breath. On 3, do three things: let the breath out, let your eyes relax but keep them closed, and let your body float. Then let one hand float up in the air like a balloon. Develop a pleasant sense of floating throughout your body. After some formal exercises such as this, it is often possible to simply ask to speak with a given alter personality, without the formal use of hypnosis. Merely asking to talk with a given identity usually suffices after a while.

c. Memory Retrieval

The therapy becomes an integrating experience of information sharing among disparate personality elements. In conceptualising DID as a chronic PTSD, the psychotherapeutic strategy involves a focus on working through traumatic memories, in addition to controlling the dissociation. Controlled access to memories greatly facilitates psychotherapy. As in the treatment of patients with dissociative amnesia, a variety of strategies can be employed here too to break down amnestic barriers. Using hypnosis to go to that place in imagination and ask one or more such parts of the self to interact can be helpful. Once these memories of earlier traumatic experience have been brought into consciousness, it is crucial to help the patient work through the painful affect, inappropriate self-blame, and other reactions to these memories. It may be useful to have the patient visualize the memories rather than relive them as a way of making their intensity more manageable. It also can be useful to have the patient divide the memories onto two sides of an imaginary screen, as for example, picturing on one side what the abuser did and on the other side how the patient tried to protect himself/herself from the abuser.

These approaches help individuals work through traumatic memories, enabling them to bar the memories in consciousness, and therefore reducing the need for dissociation as a means of keeping such memories out of consciousness. The information retrieved from memory in these ways should be reviewed, traumatic memories put into perspective, and emotional expression encouraged and worked through, with the goal of sharing the information as widely as possible among the various parts of the patient's personality structure. Instructions to other alter personalities to 'listen' while a given alter is talking, and reviewing previously dissociated material uncovered, can be helpful. The therapist conveys his/her desire to disseminate the information.

d. The 'Rule of Thirds'

The rule of the thirds involves that the therapist spends the first third of the psychotherapy session assessing the patient's current mental state and life problems and defining a problem area that might benefit from retrievals into conscious memory and working through; spends the second third of the session assessing and working through this memory; and finally allows the third part for helping the patient assimilate the information, regulate and modulate emotional responses, and discuss any responses to the therapist and plans for the immediate future. It is good to use this final third of the session for debriefing and helping the patient to reorient to attempt to integrate the new material, to transmit information across personalities, and to prepare to terminate the session. There may be resistance on the part of the patient to sharing of information across personalities. Appropriate limits must be set about self-destructive or threatening behaviour, and

agreements made regarding physical safety and treatment compliance; and other matters must be presented to the patient in such a way that dissociative ignorance is not an acceptable explanation for failure to live up to the agreements.

e. Traumatic Transference

Here we speak about patients who have been physically and sexually abused. They have experienced presumed caretakers who acted in an exploitative and sometimes sadistic fashion. The patients may expect the same from the therapist. It is good to keep these issues in mind and make them frequent topics of discussion. Attention to these issues can diffuse, but not eliminate, such traumatic transference distortions of the therapeutic relationship.

f. Integration

The ultimate goal of psychotherapy is integration of the disparate states. There can be considerable resistance from the part of the client to this attempt. Early in therapy, the patient views the dissociation as tremendous protection. The patient may experience efforts of integration as an attempt on the part of the therapist to destroy personalities. These fears must be worked through and the patient shown how to control the degree of integration, giving the patient a sense of gradually being able to control his/her dissociative processes in the service of working through traumatic memories. The goal of psychotherapy is mastery over the dissociative process, controlled access to the dissociative states, integration of warded-off painful memories and material, and a more integrated continuum of identity-memory-consciousness.[19]

(2) Psychopharmacology

There is not enough evidence to indicate that medication of any type has a direct therapeutic effect on the dissociative process manifested by DID patients. Actually, most dissociative symptoms seem relatively resistant to pharmacological intervention. Therefore, pharmacological treatment has been limited to the control of signs and symptoms affecting DID patients or comorbid conditions rather than the treatment of dissociation per se.

Though benzodiazepines have been employed to facilitate recall through controlling secondary anxiety associated with retrieval of traumatic memories, the result is not encouraging. In

fact, sudden mental state transitions induced by medications may increase rather than decrease amnestic barriers. Thus, inducing state changes pharmacologically could in theory add to difficulty in retrieval. However antidepressants are the most useful class of psychotropic agents for patients with DID. Such patients frequently have dysthymic disorder or major depression as well, and when these disorders are present, specially with somatic signs and suicidal ideation, antidepressant medication can be helpful. However its use should be limited to the treatment of DID patients who experience symptoms of major depression. The newer selective serotonin reuptake inhibitors (SSRIs) are effective at reducing comorbid depressive symptoms and have the advantage of far less lethality in overdose compared with tricyclics and monoamine oxidase inhibitors (MAOIs). Antipsychotics are rarely useful in reducing dissociative symptoms. Anticonvulsants have been used to treat seizure disorders, which have a high rate of comorbidity with DID, comorbid mood disorder, and the impulsiveness associated with personality disorders. These agents are rarely definitively helpful and they do have high incidence of serious side effects.[20]

8. Depersonalisation Disorder

(DSM-IV Code: 300.6 & ICD-10 Code: F48.1)

1) Diagnostic Criteria[21]

Diagnostic Criteria for Depersonalisation Disorder

A. Persistent or recurrent experiences of feeling detached from, and as if one is an outside observer of, one's mental processes or body (e.g., feeling like one is in a dream).

B. During the depersonalisation experience, reality testing remains intact.

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

D. The depersonalisation experience does not occur exclusively during the course of another mental disorder, such as Schizophrenia, Panic Disorder, Acute Stress Disorder, or another Dissociative Disorder, and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., temporal lobe epilepsy).

2) Differential Diagnosis[22]

In Common with	Characteristics Shared	Exclusively characteristic of Depersonalisation Disorder or of the disorder with which it is compared or difference between the two disorders
Symptoms due to a Specific General Medical Condition	Depersonalisation	Here the symptoms appear as a consequence of a specific general medical condition like epilepsy
Symptoms due to a Substance	Depersonalisation	The symptoms are directly caused by a substance

3) Treatment

Depersonalisation is most often transient and may remit without formal treatment. Recurrent or persistent depersonalisation should be thought of both as a symptom in and of itself and as a component of other syndromes requiring treatment, such as anxiety disorders and schizophrenia.

The symptom itself may respond to self-hypnosis training. Often, hypnotic induction will induce transient depersonalisation symptoms in patients. This is a useful exercise because by having a structure for inducing the symptoms, one provides patients with a context for understanding and controlling them. The symptoms are presented as a spontaneous form of hypnotic dissociation that can be modified. Individuals for whom this approach is effective can be taught to induce a pleasant sense of floating lightness or heaviness in place of the anxiety-related somatic detachment. Often, the use of an imaginary screen to picture problems in a way that detaches them from the typical somatic response is also helpful.

Other treatment modalities employed include behavioural techniques, such as a paradoxical intention, record keeping, and positive reward; flooding; psychotherapy, especially psychodynamic; and psychoeducation. It is also suggested that one could use psychotropic medications, including psychostimulants, antidepressants, antipsychotics, anticonvulsants, and benzodiazepnes. Some have suggested electroconvulsive therapy.[23]

9. Dissociative Trance Disorder

(The diagnostic criteria for DSM-IV dissociative trance disorder appear in Appendix G: "Criteria Sets and Axes Provided for Further Study.")

1) Research Criteria[24]

Research Criteria for Dissociative Trance Disorder

A. Either (1) or (2):

(1) Trance, i.e., temporary marked alteration in the state of consciousness or loss of customary sense of personal identity without replacement by an alternate identity, associated with at least one of the following:

(a) narrowing of awareness of immediate surroundings, or unusually narrow and selective focusing on environmental stimuli

(b) stereotyped behaviours or movements that are experienced as being beyond one's control

(2) possession trance, a single or episodic alteration in the state of consciousness characterized by the replacement of customary sense of personal identity by a new identity. This is attributed to the influence of a spirit, power, deity, or other person, as evidenced by one (or more) of the following:

(a) stereotyped and culturally determined behaviours or movements that are experienced as being controlled by the possessing agent

(b) full or partial amnesia for the event

B. The trance or possession trance state is not accepted as a normal part of a collective cultural or religious practice.

C. The trance or possession trance state causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The trance or possession trance state does not occur exclusively during the course of a Psychotic Disorder (including Mood Disorder With Psychotic Features and Brief Psychotic Disorder) or Dissociative Identity Disorder and is not due to the direct physiological effects of a substance or a general medical condition.

(This dissociative trance disorder should not be considered in individuals who enter trance or possession states voluntarily and without distress or impairment in the context of cultural and religious practices.)

2) Differential Diagnosis[25]

In Common with	Characteristics Shared	Exclusively characteristic of Dissociative Trance Disorder or of the disorder with which it is compared or difference between the two disorders
General Medical Condition or a Substance	Trance	Here the trance is directly caused by the general medical condition or a substance
Schizophrenia, Mood Disorder With Psychotic Features, or Brief Psychotic Disorder	Hearing or seeing spiritual beings and being controlled or influenced by others (may be confused with hallucinations and delusions)	The trance state may be distinguished by its cultural congruency, its briefer duration, and the absence of the characteristic symptoms of these other disorders.
Dissociative Identity Disorder	Similar symptoms	Persons with trance and possession symptoms typically describe external spirits or entities that have entered their bodies and taken over.

3) Cultural Context

Dissociative phenomena are ubiquitous around the world, occurring in virtually every culture. These phenomena seem to be more prevalent in the less heavily industrialized second- and third-world countries, although they can be found everywhere. For this reason, some scholars have argued against the inclusion of possession or trance disorder as a DSM diagnostic category. There are descriptions of mediums or possession episodes in different cultures, but they may all serve a similar purpose. Most researchers agree that the most common clinical features of trance states are amnesia, emotional disturbances, and loss of identity. When we compare the characteristic features of the possession-trance in different groups, we find a set of similarities, including alteration in the level of consciousness, amnesia for the period of the trance, stereotyped behaviour characteristic of a deity, duration of less than 1 hour, fatigue at the termination of the trance, normal behaviour in the interval between trances, onset before age 25 years, low social class status, poor educational level, and prior witnessing of a trance.

Dissociative symptoms are widely understood as an idiom of distress. The major purposes served by possession and trance states include the need to gain power, prestige, and status and the desire to express aggressive and sexual impulses, especially given the cultural overdetermination of women's selfhood. Spirit-possession rituals may mystify the source of women's suppression and absolve women of any responsibility for an otherwise unacceptable challenge to patriarchal control. They also may provide the subject with a sense of social association and ultimately attempt to make something socially useful from feelings such as aggression that were previously socially disintegrative, may provide a release from normative structural constraints; and may facilitate role reversal and role enhancement.

Some are of the opinion that possession can be interpreted as historical discourse, usually containing tales of tradition, or even as an alternative method of healing – not different from Western psychotherapy – thus performing a wider social function. When the embodiment of an alternative identity is exercised in the cross-

cultural complex of spirit possession, it provides a conduit through which subjective suffering can be transcended and through which the past, present, and future can be expressed.

The trance and possession categories of dissociative trance disorder constitute by far the most common kind of dissociative disorder around the world. In India, dissociative trance and possession are the most prevalent dissociative disorders. DID (Dissociative Identity Disorder), which is relatively more common in the United States, is virtually never diagnosed in India. Cultural as well as biological factors may account for the different content and form of dissociative symptoms. Nevertheless, the underlying dissociative mechanism inhibiting integration of perception, memory, and identity makes these syndromes an important class of dissociative disorders.

Differences in culture clearly influence almost all mental disorders, and therefore the contents of religious delusions will be different in a Hindu or Muslim person with schizophrenia than in a Christian person with the same disorder. Depression takes a very different form in China, resembling what used to be called neurasthenia, with a variety of somatic symptoms predominating more so than the guilty ruminations seen in the West. Likewise, the variations in form of the dissociative disorders only serve to underscore the ubiquity of the dissociative mechanism. All the same, the variety of mental contents is worthy of attention. The DSM-IV Task Force voted to include dissociative trance disorder in an appendix of DSM-IV to stimulate further research on the question of whether or not it should be a separate Axis I disorder rather than an example in the category of dissociative disorders not otherwise specified, in which it was placed in DSM-III-R. The inclusion of trance and possession disorder in DSM-IV intends to develop a sense of cultural sensitivity and internationalisation of DSM. On the other hand, designating trance and possession disorder as a formal diagnostic disorder carries with it the risks in attempting to craft a global nosological system, an impossible task. Again, the composite category 'dissociative trance disorder,' encompassing both trance and possession phenomena, may be misinterpreted as 'a single, uniform diagnostic construct and may suggest a greater degree of phenomenological uniformity than exists among indigenous syndromes, creating a hybrid nosological entity without validity.

These dissociative episodes are usually understood as an idiom of distress (e.g., discomfort in a new family environment), and yet they are not viewed as normal. They are not a generally accepted part of cultural and religious practice that may often involve normal trance phenomena, such as trance dancing in the Balinese Hindu culture. Trance dancers in that culture are remarkable for being the only portion of this socially stable society able to elevate their social status. This elevation of social status is done through developing an ability to enter trance states. They are able within the social ceremony to induce an altered state of consciousness in which they dance over hot coals, hold a sword at their throat, or in other ways exhibit exceptional powers of concentration and physical prowess. This form of trance is considered socially normal and even exalted. On the contrary, trance and possession disorders are viewed by the local community as a common but aberrant form of behaviour that requires intervention.

The most common form of dissociative disorder in the West is DID – that is, the experience of fragmentation of individual identity – whereas in the East this disorder involves possession by an outside spirit, deity, or other entity. Because of the greater sociocentric organization of culture in the East, the dissociative problem would take the form of an intruding outside identity, whereas in the West it takes the form of competing internal identities. Some propose that possession trance and multiple personality disorders arose on the basis of similar histories of child abuse and the use of dissociation as a defence mechanism.[26]

4) Classification

Dissociative trance disorder has been divided into two broad categories: dissociative trance and possession trance.

(1) Dissociative Trance

Dissociative trance is known by a sudden alteration in consciousness not accompanied by distinct alternative identities. In this form, the dissociative symptoms involves consciousness rather than identity. Again, in this the activities performed are rather

simple, usually involving sudden collapse, immobilization, dizziness, shrieking, screaming, or crying. Memory is rarely affected, and amnesia, if any, is fragmented. It involves sudden, extreme changes in sensory and motor control. Classic examples include 'ataque de nervios,' which is prevalent throughout Latin America. In this the individual suddenly starts to shake convulsively, hyperventilate, scream, and exhibit agitation and aggressive movements. These behaviours may be followed by collapse and loss of consciousness. Afterward, such individuals report being exhausted and may have some amnesia for the event. Falling out occurs frequently among African Americans in the southern United States. Affected individuals may collapse suddenly, unable to see or speak even though they are conscious. They may be confused afterward but usually are not amnestic to the episode. In the Malay version of trance disorder, 'latah,' affected individuals may have a sudden vision of a spirit that is threatening them. These persons scream or cry, strike out physically, and may need restraints. They may report amnesia, but they do not clearly take on the identity of the offending spirit.[27]

(2) Possession Trance

Possession trance involves the assumption of a distinct alternate identity, usually that of a deity, ancestor, or spirit. The person often engages in rather complex activities, which may take the form of expressing otherwise forbidden thoughts or needs, negotiating for change in family or social status, or engaging in aggressive behaviour. Possession usually involves amnesia for a large portion of the episode during which the alternate identity was in control of the person's behaviour.

In Indian possession syndrome, the individual suddenly begins speaking in an altered voice with an altered identity, usually that of a deity recognizable to others. Through this voice, a person may refer to himself/herself in the third person. The person's 'spirit' may negotiate for change in the family environment or become agitated or aggressive. Possession syndrome typically occurs in a recently married woman who finds herself uncomfortable or unwelcome in her mother-in-law's home. Usually such individuals are unable to express their discomfort directly.[28]

5) Comparison of Western and Eastern Types of Dissociative Syndromes[29]

Comparison of Western and Eastern Types of Dissociative Syndromes

Dissociative Phenomenon	Western	Eastern
Identity	Dissociative identity disorder and Multiple personality disorder: multiple internal identities	Possession trance: control by external identities
Memory	Dissociative fugue; Dissociative amnesia	Secondary in dissociative trance, more common in possession trance
Perception	Depersonalisation disorder	Dissociative trance (e.g., latah, ataque de nervios)
Consciousness	Acute stress disorder	Dissociative trance

6) Treatment

Treatment varies from culture to culture. Most syndromes occur within the context of acute social stress and thus serve the purpose of recruiting help from the family and other support systems or removing the subject from the immediate danger or threat. Ceremonies to remove or appease the invading spirit are commonly used. The role of psychiatry should be focused on ruling out any possible organic cause for the symptoms displayed, treating comorbid psychiatric conditions (if any are present), avoiding excess medication, understanding the social context and role of the syndrome, and facilitating a favourable outcome.[30]

7) Dissociative Disorder Not Otherwise Specified

(DSM-IV Code: 300.15 & ICD-10 Code: F44.9)

In this category we include disorders in which the predominant feature is a dissociative symptom (i.e., a disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment) that does not meet the criteria for any specific Dissociative Disorder. For example[31]

1. Clinical presentations similar to Dissociative Identity Disorder that fail to meet full criteria for this disorder. Examples include presentations in which a) there are not two or more distinct personality states, or b) amnesia for important personal information does not occur.
2. Derealization unaccompanied by depersonalisation in adults.
3. States of dissociation that occur in individuals who have been subjected to periods of prolonged and intense coercive persuasion (e.g., brainwashing, thought reform, or indoctrination while captive).
4. Dissociative trance disorder: single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviour or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by a new identity, attributed to the influence of a sprit, power, deity, or other person, and associated with stereotyped 'involuntary' movements or amnesia. Examples include 'amoi" (Indonesia), 'bebainan' (Indonesia), 'latah' (Malaysia), 'pibloktoq' (Arctic), 'ataque de nervios' (Latin America), and possession (India). The dissociative or trance disorder is not a normal part of a broadly accepted collective cultural or religious practice.
5. Loss of consciousness, stupor, or coma not attributable to a general medical condition.
6. Ganser syndrome: the giving of approximate answers to questions (e.g., '2 plus 2 equals 5') when not associated with Dissociative Amnesia or Dissociative Fugue.

8) Acute Stress Disorder

(Although acute stress disorder is classified among the anxiety disorders in DSM-IV, it is good to make mention of it in this chapter because half of the symptoms of this disorders are dissociative in nature. For the full treatment of this disorder, kindly refer to the chapter on Anxiety Disorders)

10. Conclusion

The dissociative disorders constitute a challenging component of psychiatric illnesses. The failure of integration of memory,

identity, perception, and consciousness seen in these disorders results in symptomatology that illustrates fundamental problems in the organization of mental processes. Dissociative phenomena often occur during and after physical trauma but also may represent transient or chronic defensive patterns. Dissociative disorders are generally treatable and constitute a domain in which psychotherapy is a primary modality, although pharmacological treatment of comorbid conditions such as depression can be quite helpful. The dissociative disorders are ubiquitous around the world, although they take a variety of forms. They represent a fascinating window into the processing of identity, memory, perception, and consciousness, and they pose a variety of diagnostic, therapeutic, and research challenges.[32]