Module-15

Psychological Disorders

Unlike what is taught to those doing major in clinical psychology, here the focus would be on those disorders that affects adjustment level relatively more. The diagnostic and statistical manual of mental disorders list a whole set of psychological disorders such as disorders first diagnosed in infancy, childhood or adolescence (mental retardation, learning disorders, motor skills and communication disorders, etc.), delirium, dementia, amnestic and other cognitive disorders, mental disorders due to general medical conditions, substance-related disorders, psychotic disorders, mood disorders, anxiety disorders, somatoform disorders, factitious disorders, dissociative disorders, sexual and gender identity disorders, eating disorders, sleep disorders, impulse-control disorders, adjustment disorders, and personality disorders. Of these, only adjustment and personality disorders will be discussed with reference to their diagnostic criteria. Impulse-control disorder has already been discussed as part of aggressive behaviour. Let us now look at the causes of psychological disorders.

Causes of psychological disorders

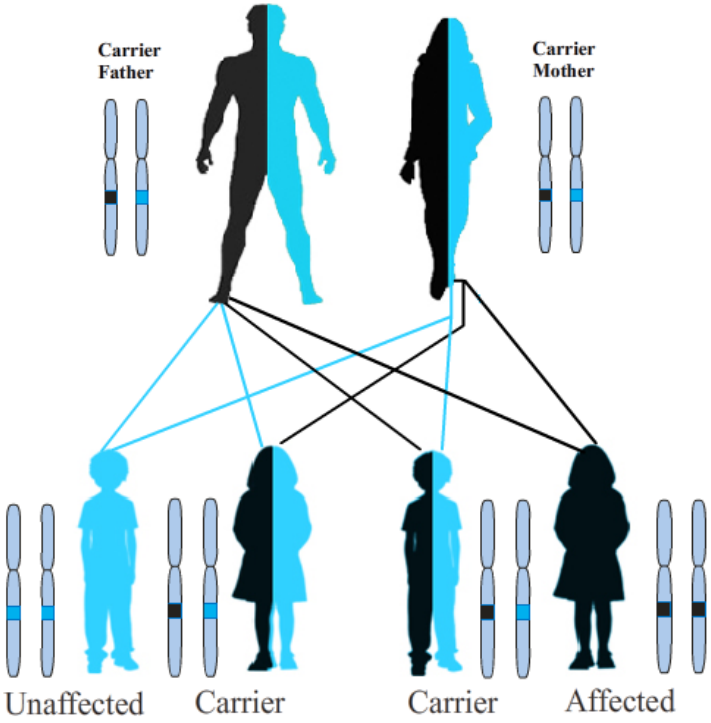
The table below summarizes the major causes of psychological disorders.

Biological	Constitutional	Socio-cultural	Psychological/ Interpersonal
Genetic	Physique	Mass violence or war	Pathogenic family patterns

Biochemical		Economic problems	Maladaptive family structure
Organic		Group prejudice	Pathological interpersonal relationship
		Accelerating social change	Severe stress

Biological causes

Biological causes of psychological disorders include genetic, biochemical and organic factors. Human beings have 23 pairs of chromosomes— 22 pairs of autosomes and one pair of sex chromosome. A chromosome has few hundred to several thousand genes. Thus, we have 30,000 – 40,000 genes and approximately six billion DNA base pairs. This can help you imagine the significance of genetic factors for psychological disorders. Children inherit the chromosomes from both the parents and the environment also exerts selective demands. Human behaviour is an outcome of the interplay between the two. An important phenomenon in behavioural genetics is mutation. It refers to changes in the genomic sequence. This could affect a single DNA base or the segment of a chromosome. The figure given below illustrates the consequence for the next generation when both the parents carry a particular anomaly.



Mutation could either be germline or somatic. Germline mutation or hereditary mutation is inherited from the parents somatic mutation is acquired. Mutation in DNA of certain cells due to exposure to ultraviolet radiation is an example of somatic mutation. Besides this genes are responsible for transcription and translation of DNA into proteins which, in turn, contribute to brain development. Brain anatomy, neurotransmitters, receptors, and neuronal interconnections are all regulated by the genes.

Chromosomal aberration and faulty genes are responsible for many disorders of interest of the psychologists. Behaviour genetics research endorse association between that a variant of dopamine receptor gene and ADHD. Polymorphism of DRD4 (dopamine D4 receptor gene) is known as 7-repeat form. Individuals with 7-repeat form of DRD4 have thinner tissue in the right orbitofrontal/ inferior prefrontal and posterior parietal cortex of the brain. Hence, the significance of genes can be visualized. Further, the brain areas controlling reading skills and language are

virtually identical in identical twins as they share exactly the same genes. This helps understand why certain disorders run in families. Let us take another example. Human beings learn vocalization through imitation. Mutation in FOXP2 gene has been found to cause verbal dyspraxia. This is a developmental disorder with significant disruption of speech and language. The inheritance of FOXP2 is consistent with an autosomal dominant mutation. It leads to disorder of orofacial movement thus causing speech and language disorder.

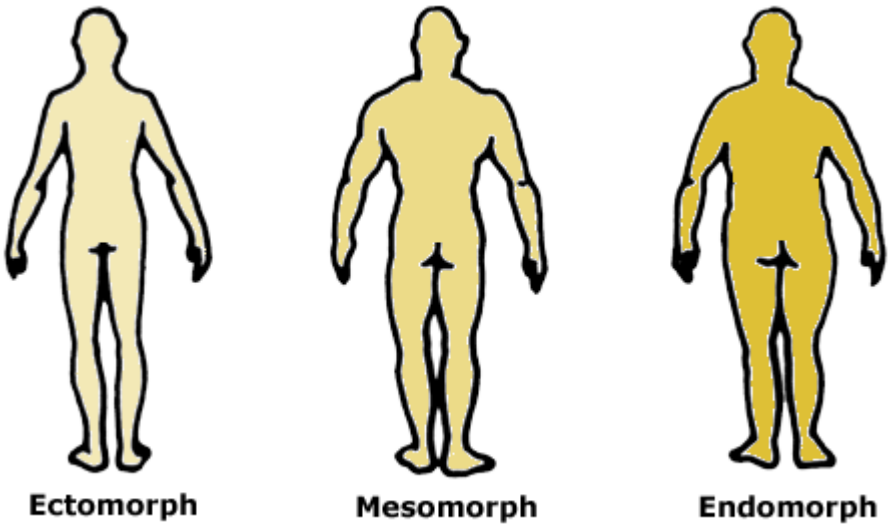
There could also be the possibility of genetic predisposition to specific disorders. For example, Tay-Sachs is a hereditary disease affecting the nervous system mostly found in the Jews with Middle-European ancestors. Sickle cell anemia is also a hereditary disease affecting red blood cells. Similarly, Huntington's chorea is a hereditary disease affecting the nervous system. Even incidences of psychotic disorders like schizophrenia have been found to be higher among blood relatives. It has been found to be 86.2% in the identical twins. All these findings establish genetic factors as a cause of psychological disorders.

Biochemical factors are equally vital for the psychological disorders. The other web course titled *Biological bases of behaviour* elaborately discusses the importance of hormones and neurotransmitters for our brain and body. Body chemistry has been found important for the psychological disorders. For instance, dopamine and serotonin are involved in muscle control, memory, sleep, and emotional behaviour. They are also associated to some illnesses like Parkinson's disease and mood disorders. The whole range of organic disorders such as mental retardation, degenerative disorders such as dementia, circulatory disorders such as ceribroarterioscelorosis, head injury, and so forth have their root in the cranial anatomy and functions.

Constitutional causes

The course *Introduction to Psychology* talks about the personality theories at length. One major set of theories are classified as type approach to personality which is primarily based on the understanding of psychological characteristics on the bases of physique. The classification of personality by Hippocrates, Sheldon, Eyesenck, and Friedman and Rosenman fall in this category. In 400 BC Hippocrates classified human beings into four categories— sanguine, melancholic, choleric and phlegmatic types. According to him sanguine type individuals are cheerful, active, and confident whereas melancholic type individuals are depressed. The choleric type individuals are hot tempered while the phlegmetic type individuals are calm and slow.

Another categorization was done by Sheldon. On the basis of physique, he classified human beings into three types— endomorph, ectomorph and mesomorph. In terms of physical appearance endomorphs are short and plump; ectomorphs are tall and thin, whereas mesomorphs are heavy and muscular. The illustration given below shows the body built of the three types.



In terms of personality characteristics, endomorphs were supposed to be sociable and relaxed, ectomorphs restrained and self-conscious, and the mesomorphs noisy, aggressive, and active. However, this overgeneralization of personality and body types was discarded. It is being discussed here as you find reference to personality types and psychological disorders. Later, Eyesenck's classification also came forward with trifurcated bipolar axes— extroverts and introverts, stable and neurotic, and psychotics. Friedman and Rosenman proposed type-A and B personalities suggesting type-A as competitive, restless, high achieving, active, and aggressive and type-B having characteristics opposite of type-A.

Besides this, physical handicap, especially amputation in later part of life and deprivation leading to improper physical growth can also be detrimental of one's mental health. The postmortem based classic work of Winick (1968) proved that children dying due to malnutrition had 60% less neurons in their brain compared to normal infants of their age.

Socio-cultural causes

Besides biological and constitutional approach to the understanding of causal factors of psychological disorders the other important factor is the socio-cultural causes. Several socio-cultural factors adversely affect our adjustment process and at times they lead to disorders too.

Persistence of violence could be extremely threatening for the self as well as for the loved ones. Right from the systemic level to a micro level, violent experience within the family and society leaves a deep psychological scar on the psyche of the sufferer. We have already talked about ‘partition psychosis’. The complete absence of safety could challenge one of the important sociogenic motives besides making the individual realize the inherent instability in his/ her life.

Group prejudice and discrimination are another source of profound psychological scar. The fact that you have been deliberately neglected and deprived equal opportunity of growth and development by the society could be very detrimental. In several societies there has been a systematic approach to neglect a group of individuals or one single individual based on their identity, it could be religious identity, caste based identity, and so forth. The feeling of dejection, the sense of segregation, and the realization of isolation could combine with the unequal opportunity of reshaping one’s life leading to tremendously pessimistic sentiment. This, in turn, can adversely affect one’s mental health.

Economic concerns and employment problems are another source of unrest for one’s mental state. Basically, it also challenges one of important sociogenic motive, the need for security. Continuous struggle to maintain stability in the life has its own price and those who experience it are vulnerable to psychological problems. It has been realized that alcoholism and other drug abuse also increases in such cases, making the problems even worse.

Accelerating social changes are another big challenge. The rate at which the contemporary world is changing puts forth a bigger challenge before all of us— adjusting to the changing scenario at its pace. Changes at several fronts and your limitation to cope with it or adapt to it can affect your adjustment. If too intense, it can have adverse effect as well. For instance, India has seen big change in last one and half decade. The contemporary society is largely technologically driven. Now take example of railway reservation. Earlier the main station in the city used to have a reservation counter. People had to go there, stand in long cue and then they were given a general travel ticket along with a small receipt which basically endorsed that one had paid the fee for a reserved seat. Allotment of berth was manually done. Right from there we now have the option of booking online. The payment can be made through various modes. Now even the ticket is not needed. The SMS received on the mobile handset is sufficient enough as a travel document. People had to put a lot of effort to switch to that mode. Those working as reservation clerks with the railways for years had to learn usage of computer, those travelling by trains had to adapt to the new system which was largely virtual. Although a larger chunk of the society adapted with little effort, some had to put extra effort and some preferred to develop inability to completely adapt the system.

Right from railways to banking where operation of the ATM machines was considered extremely difficult in terms of operation by the senior citizens. The functions are temporally driven and one is supposed to follow the instructions, perform the task of pressing buttons within predefined time limit and so forth. Overall, it increased the cognitive load on the elderly people who were already facing decline in certain bodily functions. You can still find people who prefer to go to the bank for all types of work that can be otherwise performed using an ATM machine. My personal experience with the elderly people during various phases of data collection for

diverse research problems tells me that a substantial number of them find adaption to rapid technologically driven changes very difficult. It ranges from usage of the mobile phones to social networking sites.

Let us take another example. The Indian road network, where the arterial road joins the main highway, is largely accident prone. A friend of mine from Mumbai spent his childhood in a flat near to the present day junction that connects to the Mumbai-Agra highway. When he was a small child, his mother used to hold his hands to help him cross the road. Today the mother, who is little more older compared to those days, cannot cross the road. She explains her difficulty of not being able to do something that she had done for years despite zebra crossing and signals. Her life experience has made her extremely reluctant to move out of her residential society. This, in turn, has lead to self-imposed confinement. Such confinements and similar consequences could adversely affect one's mental well-being. Violence, group prejudice, social discrimination, sustained economic and employment problems and accelerating social changes, all of them basically make you realized that your existence is at stake and such that you might run shot of the resources available to you for coping.

Psychological causes

Several psychological factors play significant role in balancing our lives. The nature, intensity, duration and appraisal of these life circumstances affect our mental health. Maternal deprivation, pathogenic family pattern, maladaptive family structure, pathological interpersonal relationship and severe stress are the important psychological factors that might have detrimental effect on an individual. Several studies have confirmed the significance of emotional attachment

between the mother and child. Absence of the mother figure can adversely influence emotional, intellectual and social stimulation and hence learning of such children. Many such kids might face institutionalization which, in turn, could have its own negative impact. Some children might experience masked deprivation, wherein even in the physical presence of the mother they could experience inadequate or distorted motherly care.

Many, if not all, psychological factor has its root in the family system. One could have a faulty parent-child relationship, parents who are overprotective or impose high restrictions; they might be over permissiveness allowing their children higher chances of doing things their way or they themselves indulge in the activities of their children. All such extremes does not allow the child learn the norms, values and practices of the society. This, in turn, make them exhibit behavioural aberration. Parents who put unrealistic demands before their children or show communication failure with them present complex situation before their kids. Faulty discipline pattern and undesirable parental model are equally damaging for the children. Inadequacy, disturbance or indulgence in anti-social activities is the maladaptive elements of the family structure that might influence onset of psychological disorders. Failure, instability and presence of pathological factors in interpersonal relationship can also have similar effect. The adverse impact of severe stressors such as failures, losses, personal limitations and lack of resources are also reported by researchers.

Although we have discussed these causes separately, practically there could be a possibility that one triggers or influences the other. For instance, having chromosomal aberration will directly affect the child; at the same time it can be a major stressor for the parent, which again affects the family structure and indirectly comes back to the child. Many such scenarios are possible.

After deliberating the casual factors let us now become aware of the distinction between neurotic and psychotic disorders. Further, because this is a course on psychology of adjustment and not a clinical psychology course, we shall focus on psychotic disorders per se. Rather we will look at the basic nature of different neurotic disorders and then deliberate upon adjustment and personality disorders.

Comparison of neurotic and psychotic disorders*:

Criteria	Neuroses	Psychoses
General bahaviour	Maladaptive avoidance behaviour, with mild to moderate impairment of personal and social functioning	Severe personality decompensation; marked impairment of contact with reality, severe impartment of personal and social functioning
Nature of symptoms	Wide range of psychological and somatic symptoms, but no hallucinations or other extreme deviations in thought, affect or action	Wide range of symptoms, with extreme deviations in thought, affect and action
Orientation	Slight (if any) impairment of orientation to environment with respect to time, place	Frequent loss of orientation to environment with respect to

	and person	time, place and person
Insight (self understanding)	Frequently some understanding of own maladaptive behaviour, but with a seeming inability to change it on one's own	Markedly impaired understanding of current symptoms and behaviours
Physically destructive behaviour	Behaviour rarely dangerous or physically injurious to anyone	In some cases behaviour may be dangerous to self or others
Causal factors	Emphasis on failure to acquire needed competencies, and/ or on learnt maladaptive behaviour	Emphasis on maladaptive learning, decompensation under excessive stress and possible biochemical irregularities

*Source: Coleman, J. C. (1976). *Abnormal psychology and modern life*. Scott Foresman & Company.

Neurosis: Types and Symptoms*

Anxiety	Free floating anxiety, usually punctuated by acute attacks.

Phobia	Irrational fears leading to anxiety if not heeded. May lead to a pervasive pattern of avoidance behaviour.
Obsession-compulsion	Repetitive thoughts and impulses which are irrational, but persists nonetheless.
Hysteria	Conversion type: Simulation of actual organic illness, such as paralysis or epilepsy, without organic pathology. Dissociative type: Dissociation of certain aspects of consciousness or identity from self-structure. Symptom pattern may take the form of amnesia, fugue or multiple personality.
Hypochondriasis	Preoccupation with bodily processes and presumed disease.
Neurasthenia	Chronic fatigue, weakness and lack of enthusiasm.
Depressive neurosis	Abnormally prolonged dejection associated with life stress.

*Source: Coleman, J. C. (1976). *Abnormal psychology and modern life*. Scott Foresman & Company.

Adjustment disorders

Disrespect for the social norm and tendency to violate them, manifesting distinct behaviour that is not so commonly observed and other persistent pattern of behaviour are likely to characterize one or the another form of disorder. Although, the criteria adopted by the American Psychiatric Association for diagnosis has been reproduced here, one must be aware of couple of relevant issues. Not all diagnostic criteria (in its full form) have been reproduced here. Further, as this is a course on the psychology of adjustment, several other technical details have deliberately not been provided here. These details, such as diagnostic and associated features and course of the disorders, are suitable for those specializing in selected areas of psychology and are hence not provided here. Even this lecture is not referring to differential diagnosis. Here the focus would be on two categories of disorders that are crucial for us to understand— adjustment disorders and personality disorders.

Stress is an inevitable factor in life. One might experience a single stressful event or there could a combination. For instance, failure in a relationship is a single event that might act as a stressor where as breakdown of a relationship and failure in examination at the same time can have a combined effect. Most of the time we succeed overcoming them. In cases where our response to a stress is peculiar enough to indicate emotional or behavioural symptoms, adjustment disorders come into picture. These symptoms are a cause of concern because they impair one's social, academic or occupational functioning.

In the recent times we saw farmers in deep crisis forcing many of them to take extreme steps. Popularly referred as *Vidarbha* crisis, it was the focus of national media for quite some time (see the news below published in Hindustan Times, January 4, 2011). In terms of stressor, this can be considered a recurrent stressor as it was affecting the farmers in successive seasons.

6 farmers end life in 72 hours

IN VIDARBHA The victims took the extreme step despite the market rate of raw cotton being reasonably satisfactory

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AMONG THE LATEST VICTIMS, TWO ARE FROM YAVATMAL AND ONE EACH FROM WARDHA, AMRAVATI, AKOLA AND BHANDARA DISTRICTS

NAGPUR: The agrarian crisis continues to drive distressed farmers in Vidarbha to suicide. Six more farmers ended their lives in the erstwhile cotton belt in the last 72 hours.

According to reports reaching here on Tuesday, most of the victims were cotton growers and the tragedy occurred when the prevailing rate of raw cotton in the market is approximately Rs 4,200 a quintal. Among the latest victims, two are from Yavatmal and one each from Wardha, Amravati, Akola and Bhandara districts.

The district collector of Yavatmal Sanjay Deshmukh was not available for comments.

Fifty-two farmers had committed suicide in December 2010.

Kishore Tiwari of Vidarbha Jan Anodolan Samiti, an organisation that is documenting farmers' suicides in the region, said crop failure was the primary reason for the latest farmers suicides.

"The market rate of raw cotton was reasonably satisfactory despite a meagre guarantee price of Rs 3,000 per quintal announced by the government. But the farmers could not cope with the situation because of crop failure due to untimely rains this season," he said.

Tiwari criticised the state government for its lackadaisical approach towards the cotton growers of Vidarbha while announcing the relief package after the unseasonal rains damaged crops.

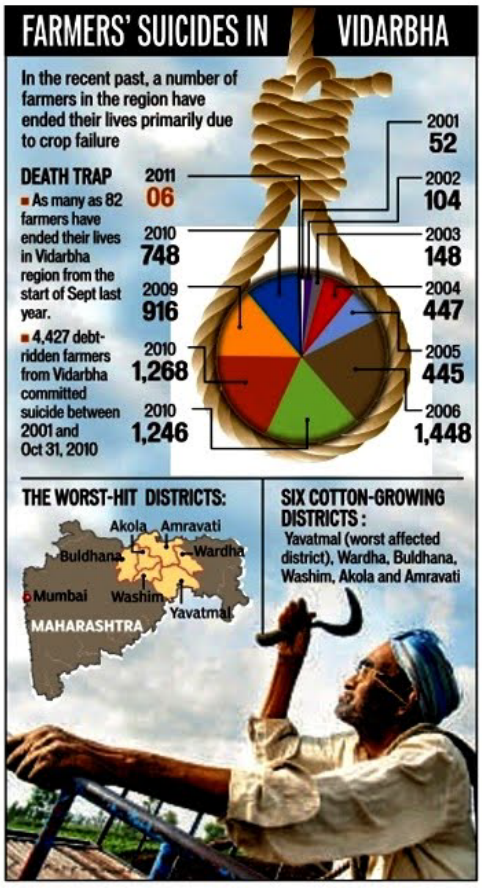
While grape growers of the state got a compensation of Rs 25,000 per hectare from the government, cotton growers got a only Rs 5,000 per hectare. "This is an insult to the crisis-ridden cotton growers of Vidarbha," he said.

The issue figured in the winter session of the state legislature held in Nagpur in December.

The state's rehabilitation minister, Patangrao Kadam, had told the Assembly that 4,427 debt-ridden farmers from Vidarbha had committed suicide between 2001 and October 31, 2010.

In the initial years when farmers distress came to attract public attention it was said that indebtedness through use of Bt Cotton were the main cause for farmers suicide.

Here it is important to notice that in the context of Indian history the moneylender is considered to be a particularly evil person and the farmer an unwitting subject of his machinations. Moreover, in recent times there has been a considerable ideologically driven movement against the use of Bt crops.



There could be a continuous stressor such as living in a crime dominant locality. I know of a case where a family finally migrated to another city in India because they had to suffer from criminal neighborhood problem. They sold off their property and settled in another city. In an interesting study Ferrell, Mathur, Meek and Piven (2012) studied the influence of neighbourhood crime on travel behaviour and found that high neighbourhood crime rate discourage people from

walking or using bicycle. You can imagine the psychological price one has to pay for a crime infested neighbourhood. Such stressors might affect an individual, a family or a large group and could be associated with specific events. For instance, look at the news item published in a leading daily, Hindustan Times, describing the recent violence in Assam.

HOMELESS IN HOMELAND

Thousands have fled their villages as a fallout of Bodo-Muslim clashes in Assam. A look at the conflict:

THE ROOT CAUSE

- The main source of conflict between the Bodos and immigrant Muslims is control over land. Immigrant Muslims have been migrating from Dhubri to Kokrajhar district's Gosaigaon sub-division in large numbers over the past five years
- All Bodoland Muslim Students' Union from time to time raises its voice against "atrocities" of Bodos on Muslims. They also allege that Bodo Territorial Council, created in 2003, is neglecting Muslims.

THE CURRENT TROUBLE

July 6: Two Muslims were killed in Kokrajhar
July 20: Two leaders of All Bodoland Minority Students' Union were shot at near Kokrajhar by unidentified people
July 21: Nine persons killed and 12 injured in four separate incidents of violence in Kokrajhar in clashes that started on Friday night
July 22: Eight more deaths reported
July 23: Violence spreads to Dhubri district.

STATE ACTION

- **50,000** people have taken shelter in relief camps set up by the government.
- Centre deploys 1,500 more police personnel – in addition to 1,400 sent on Monday

- (Top left) Dimol villagers in Kokrajhar district wait to be shifted to a relief camp; (above) People from disturbed areas moving to safer places on Tuesday. PTI PHOTOS

This event became a source of severe stress for those within as well as outside the geographical boundaries of the state concerned. Look at the two images published in The Hindu, another leading daily.

	
Source- The Hindu, Kokrajhar, Assam (July 24, 2012) People of Dimol village leave their homes following ethnic clashes in Kokrajhar district, Assam. Photo: PTI.	Source- The Hindu, Bangalore/Chennai, (August 16, 2012) People from the Northeast at the Bangalore City Station to board a special train bound for Guwahati. Photo: K. Bhagya Prakash

These two images clearly show how a single event has affected a large number of people who are geographically separated by approximately 3000 kilometers. A single event, which is a stressor, has caused similar behavioural reaction. The table given below shows the diagnostic criteria set by the American Psychiatric Association for adjustment disorders.

Diagnostic criteria for Adjustment Disorders*	
A.	The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
B.	These symptoms or behaviours are clinically significant as evidenced by either of the following—
	(1) Marked distress that is in excess of what would be expected from exposure to the stressor
	(2) Significant impairment in social or occupational (academic) functioning.
C.	The stress related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.
D.	The symptoms do not represent Bereavement.
E.	Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

*Source- Diagnostic and statistical manual of mental disorders (4th edition), American Psychiatric Association.

The acute and chronic nature of adjustment disorders is temporally decided. If the symptoms lasts less than six months then the disorder is classified as acute whereas if it lasts for six months or exceeds beyond it then it is classified as chronic. Further, it has six subtypes based on the prominence of the symptoms. The subtypes and their characteristics are summarized in the table given below.

Subtype	Characteristics
1. With depressed mood	Manifestations of depressed mood, tearfulness or feelings of hopelessness are the dominant symptoms.
2. With anxiety	Manifestations of nervousness, worry or jitteriness are the dominant symptoms. Fear of separation from the major attachment figure might be manifested in children.
3. With mixed anxiety and depressed mood	Manifestations of combination of depression and anxiety.
4. With disturbance of conduct	Manifestation of disturbance in conduct that violates age-appropriate social norms and rules.
5. With mixed disturbance of emotions and conduct	Manifestations of emotional symptoms, such as anxiety, as well as disturbance in conduct.
6. Unspecified	Manifestation of maladaptive reactions to stressors that are not classified (above). Such reactions include physical complaints, social withdrawal or academic inhibition.

Although, the diagnostic criteria provide the basic premise for classification of any disorder, including adjustment disorders, the cultural context is another important determinant of adjustment disorders. Whether a reaction is maladaptive or disproportionate is guided by the culture specific norms for that very given age and gender.

Personality disorders

Stress also aggravates personality disorders. Personality disorders are defined as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture." With an onset in adolescence or early adulthood, the manifested behaviour is pervasive and inflexible leading to distress or impairment. This pattern is manifested in two (or more) of the following areas— cognition, affectivity, interpersonal functioning and impulse control. We shall have a cursory look at them. The table given below shows the diagnostic criteria set by the American Psychiatric Association for cluster A personality disorders.

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 or 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 or her

(4) Reads hidden demeaning or threatening meanings into benign remarks or events
(5) Persistently bears grudges (unforgiving of insults, injuries, or slights)
(6) Perceives attacks on his or 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
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

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
(3) Unusual perceptual experiences, including bodily illusions
(4) Odd thinking and speech
(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 judgments about self.

*Source- Diagnostic and statistical manual of mental disorders (4th edition), American Psychiatric Association.

Cluster B personality disorders includes antisocial personality disorder, borderline personality disorder, histrionic personality disorder, narcissistic personality disorder, avoidant personality disorder, dependent personality disorder, and obsessive-compulsive personality disorder. The table given below shows the diagnostic criteria set by the American Psychiatric Association for cluster B personality disorders.

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 confirm to social norms with respect to lawful behaviour 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 with onset before age 15 years.
Diagnostic criteria for borderline personality disorder*	
A.	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) Markedly and persistently unstable sense of self
	(4) Impulsivity in at least two areas that are potentially self-damaging (such as spending, sex, substance abuse, etc.)
	(5) Recurrent suicidal behaviour, gesture, or threats, or self-mutilating behaviour
	(6) Affective instability due to a marked reactivity of mood
	(7) Chronic feelings of emptiness
	(8) Inappropriate, intense anger or difficulty controlling anger

(9) Transient, stress-related paranoid ideation or severe dissociative symptoms
Diagnostic criteria for histrionic personality disorder*
A. 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 center 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 expression of emotion
(6) Shows self-dramatization, theatrically, and exaggerated expression of emotion
(7) Is suggestible
(8) Considers relationships to be more intimate than they actually are
Diagnostic criteria for narcissistic personality disorder*
A. 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 a grandiose sense of self-importance
	(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 institution
	(4) Requires excessive admiration
	(5) Has a sense of entitlement (unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations
	(6) Is interpersonally exploitative (takes advantage of others to achieve his or her own ends)
	(7) Lacks empathy (unwilling to recognize feelings of others)
	(8) Is often envious of others or believes that others are envious of him or her
	(9) Shows arrogant, haughty behaviours or attitude
Diagnostic criteria for avoidant personality disorder*	
A.	A pervasive pattern of social inhibition, feeling 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 unusually reluctant to take personal risks or to engage in new activities because they may prove embarrassing
Diagnostic criteria for dependent personality disorder*
A. 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

(4) Has difficulty initiating projects or doing things on his or her own
(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
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, organization, or schedules to the extent that the major point of the activity is lost
(2) Shows perfectionism that interferes with task completion
(3) Is excessively devoted to work and productivity to the exclusion of leisure activities and friendships

(4) Is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values
(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

*Source- Diagnostic and statistical manual of mental disorders (4th edition), American Psychiatric Association.

The personality disorders mentioned above does invite attention of a specialist. In terms of adjustment it severely impairs the relationship that one would ideally assume between any individuals and others in his/ her society. They affect the cognitive, affective and interpersonal functioning of the individual. As these disorders are reflected in the form of a behaviour that deviates markedly from the expectations of the individual's culture, people in the society show they concern. For instance, someone with paranoid personality disorder would also have unjustified doubts about the trustworthiness of friends or associates. He/ she will also persistently bear grudges towards others. These set of behaviour is likely to make others disapprove of him or her. Similarly, someone with schizoid personality disorder will never enjoy close relationships and with show emotional coldness and detachment. This is certainly going to result into

disapproval from others and lack of friends. Someone who is always suspicious and shows inappropriate or constricted emotion will have hard time finding acceptance by others. Clinically this would be classified as schizotypal personality disorder but for the general mass such behaviour will invite rejection and disapproval and thus would always challenge the adjustment of the individual in his/ her society.