Chapter 4: Psychological Disorders

Review Questions — Review Questions

Q1 Identify the symptoms associated with depression and mania.

Depression (major depressive disorder) is a period of depressed mood and/or loss of interest or pleasure in most activities. Other symptoms include a change in body weight, constant sleep problems, tiredness, inability to think clearly, agitation or greatly slowed behaviour, excessive guilt or feelings of worthlessness, and thoughts of death and suicide. Mania is the opposite, elevated pole of mood. Manic episodes rarely appear by themselves. In bipolar I disorder (earlier called manic-depressive disorder), mania and depression alternate, sometimes interrupted by periods of normal mood. So depression is marked by low mood, loss of interest and slowed functioning, while mania appears as the contrasting episode that alternates with it.

Q2 Describe the characteristics of children with hyperactivity.

Hyperactivity is one of the two main features of ADHD, the other being inattention. Children with ADHD are in constant motion, and sitting still through a lesson is impossible for them. They fidget, squirm, climb and run around the room aimlessly. Parents and teachers describe them as 'driven by a motor', always on the go and talking incessantly. They are also impulsive: they cannot control immediate reactions or think before acting, find it hard to wait or take turns, and struggle to resist temptation or delay gratification. Minor mishaps such as knocking things over are common, and serious accidents can occur. Inattentive children also find it hard to sustain mental effort, follow instructions or finish assignments, and are easily distracted and forgetful.

Q3 What are the consequences of alcohol substance addiction?

People who abuse alcohol drink large amounts regularly and rely on it to face difficult situations. Drinking eventually interferes with their social behaviour and their ability to think and work. The body builds tolerance, so they need greater amounts to feel the effects, and they show withdrawal responses when they stop. Alcoholism destroys millions of families, social relationships and careers. Intoxicated drivers cause many road accidents. The children of such persons have higher rates of psychological problems, particularly anxiety, depression, phobias and substance-related disorders. Excessive drinking seriously damages physical health. Alcohol depresses the central nervous system, so judgment, speech and memory suffer, people may become emotional, loud and aggressive, and motor coordination, vision and hearing worsen.

Q4 Can a distorted body image lead to eating disorders? Classify the various forms of it.

Yes. A distorted body image is central to anorexia nervosa, where the person sees herself or himself as overweight despite being underweight. The chapter classifies feeding and eating disorders into three forms. (1) Anorexia nervosa: the person often refuses to eat, exercises compulsively, develops unusual habits such as not eating in front of others, may lose large amounts of weight and can even starve to death. (2) Bulimia nervosa: the person eats excessive amounts of food and then purges by laxatives, diuretics or vomiting. They feel disgusted and ashamed when bingeing and relieved of tension after purging. (3) Binge eating: frequent episodes of out-of-control eating, at higher than normal speed, continuing until uncomfortably full, even when not hungry.

Q5 "Physicians make diagnosis looking at a person's physical symptoms". How are psychological disorders diagnosed?

Psychological disorders are diagnosed by matching a person's behaviour, thoughts and emotions against standard classification systems, since there is often no physical sign. Two systems are used. The American Psychiatric Association's DSM-5 presents discrete clinical criteria that indicate the presence or absence of a disorder. The ICD-10 (Classification of Behavioural and Mental Disorders), prepared by the WHO and officially used in India and elsewhere, gives for each disorder a description of the main clinical features or symptoms, other associated features and diagnostic guidelines. Such classifications let psychologists, psychiatrists and social workers communicate about a disorder. Diagnosis also considers the four Ds: deviance, distress, dysfunction and danger. Specialised training in clinical psychology or counselling is needed for diagnosis.

Q6 Distinguish between obsessions and compulsions.

Both occur in obsessive-compulsive disorder, where people cannot control their preoccupation with specific ideas or prevent themselves from repeatedly carrying out an act. Obsessive behaviour is the inability to stop thinking about a particular idea or topic. It is a mental preoccupation, and the person often finds these thoughts unpleasant and shameful. Compulsive behaviour is the need to perform certain behaviours over and over again. It is an action, and many compulsions involve counting, ordering, checking, touching and washing, for example washing hands every time something is touched. In short, an obsession is a persistent, unwanted thought, while a compulsion is a repetitive act. Either can interfere with normal activities.

Q7 Can a long-standing pattern of deviant behaviour be considered abnormal? Elaborate.

Not necessarily. Deviance (being different, extreme or unusual) is only one of the 'four Ds'; the others are distress, dysfunction and danger. One view treats abnormal behaviour as deviation from social norms, but this is questioned because it assumes that normality is mere conformity. Norms grow from a society's culture and change over time, so behaviour accepted in one society, such as aggression in a competitive culture, may be unacceptable in another. The second view takes maladaptive behaviour as the criterion, asking whether it fosters the well-being of the individual and the group, including growth and fulfilment. So a long-standing deviant pattern is abnormal only if it is also maladaptive: distressing, dysfunctional or dangerous. Conforming behaviour can even be abnormal if it blocks optimal functioning.

Q8 While speaking in public the patient changes topics frequently, is this a positive or a negative symptom of schizophrenia? Describe the other symptoms of schizophrenia.

Frequent shifting of topics (loosening of associations or derailment) is a positive symptom. Positive symptoms are pathological excesses or bizarre additions to behaviour, and disorganised thinking and speech is one of them. Other positive symptoms are delusions (false, firmly held beliefs, such as persecution, reference, grandeur or control), hallucinations (perceptions without external stimuli, most often auditory but also tactile, somatic, visual, gustatory or olfactory), and inappropriate affect. Negative symptoms are deficits: poverty of speech (alogia), blunted or flat affect, avolition (apathy and inability to start or complete action) and social withdrawal. Psychomotor symptoms include odd grimaces and gestures, and extreme catatonia, with stupor, rigidity or posturing.

Q9 What do you understand by the term 'dissociation'? Discuss its various forms.

Dissociation is the severance of connections between ideas and emotions. It involves feelings of unreality, estrangement, depersonalisation and sometimes a loss or shift of identity. Sudden temporary alterations of consciousness that blot out painful experiences define dissociative disorders. Forms: (1) Dissociative amnesia: extensive but selective memory loss with no organic cause, often about stressful events. Dissociative fugue is a part of it, with unexpected travel away from home, a new identity and no memory of the previous one. (2) Dissociative identity disorder (multiple personality): the person assumes alternate personalities that may or may not know each other, often linked to childhood trauma. (3) Depersonalisation/derealisation disorder: a dreamlike state in which the person feels separated from self and reality.

Q10 What are phobias? If someone had an intense fear of snakes, could this simple phobia be a result of faulty learning? Analyse how this phobia could have developed.

Phobias are irrational fears related to specific objects, people or situations. They are of three types: specific phobias, social phobias (social anxiety disorder) and agoraphobia. An intense fear of snakes is a specific phobia, and it can result from faulty learning. According to the behavioural model, abnormal behaviours are learned maladaptive responses acquired through conditioning. It could develop by classical conditioning: the snake is repeatedly or even once associated with a frightening event, so the snake alone triggers fear. By operant conditioning: avoiding snakes brings relief, which rewards and strengthens the avoidance. By social learning: seeing a parent or others react fearfully teaches the fear by imitation. Since what is learned can be unlearned, the phobia can also be treated.

Q11 Anxiety has been called the "butterflies in the stomach feeling". At what stage does anxiety become a disorder? Discuss its types.

Anxiety is a diffuse, vague, very unpleasant feeling of fear and apprehension. Mild anxiety, such as before an examination, is normal and can motivate us. It becomes a disorder when it reaches high levels that are distressing and interfere with effective functioning. Types: (1) Generalised anxiety disorder: prolonged, vague, unexplained, intense fears not attached to any object, with worry, hypervigilance and motor tension. (2) Panic disorder: recurrent attacks of intense terror with breathlessness, dizziness, trembling, palpitations, and fear of going crazy, losing control or dying. (3) Phobias: irrational fears of specific objects or situations, social anxiety, and agoraphobia (fear of entering unfamiliar situations or leaving home). (4) Separation anxiety disorder: developmentally inappropriate fear of separation from attachment figures. Others include selective mutism.