Unit 10  Psychological Disorders

LEARNING OUTCOME

At the end of this topic you will learn about:

1. Describe the symptoms Anxiety Disorders
2. Explain possible causes of Anxiety Disorders
3. Describe the symptoms Mood Disorders
4. Explain possible causes of Mood Disorders
5. Describe the symptoms Schizophrenia
6. Explain possible causes of Schizophrenia
7. Describe the symptoms Somatoform Disorders
8. Explain possible causes of Somatoform Disorders
9. Describe the symptoms Sexual Disorders
10. Explain possible causes of Sexual Disorders
Psychological disorders are terms used to refer to a psychological or physiological pattern that is usually associated with distress or disability that is not expected as part of normal development or culture. The dysfunctions in psychological disorders are assumed to be the product of disruptions of thought, feeling communication, perception and motivation. Not every dysfunction leads to a disorder, only those that result in significant harm.

The recognition and understanding of psychological disorders has changed over time. Definitions, assessments, and classifications of psychological disorders can vary. However, the guideline criterion listed in the ICD, DSM and other manuals are widely accepted by mental health professionals. Categories of diagnoses in these schemes may include mood disorders, anxiety disorders, psychotic disorders, eating disorders, developmental disorders, personality disorders, and many other categories.

In many cases there is no single accepted or consistent cause of psychological disorders, although they are widely understood in terms of a diathesis-stress model and biopsychosocial model. Psychological disorders have been found to be common, with over a third of people in most countries reporting sufficient criteria at some point in their life. Mental health services may be based in hospitals or in the community.

Mental health professionals diagnose individuals using different methodologies, often relying on case history and interview. Psychotherapy and psychiatric medication are two major treatment options, as well as supportive interventions.

Treatment may be involuntary where legislation allows. Several movements campaign for changes to mental health services and attitudes, including the Consumer/Survivor Movement. There are widespread problems with stigma and discrimination.

Jerome Wakefield propose the idea of mental disorder as “harmful dysfunction”, meets two criteria:

i) The condition causes harm according to social values of a persons culture (suffering, unable to work); and

ii) The condition results from and underlying mechanism that fails to perform according to its natural function.

Characteristics include:

- Present distress (painful symptoms);
- Disability (impairment in important areas of functioning); and
- Significantly increased risk of suffering pain, death, disability or loss of freedom
**Insanity** is a legal term that refers to judgments about whether a person should be held responsible for criminal behavior if he or she is also mentally disturbed.

Another approach is to define abnormal behavior in terms of statistical norms – how common or rare it is in the general population.

**Prevalence of Psychological Disorders**

![Figure 10.1: Percentage of Adults Affected with Psychological Disorders](image)

![Figure 10.2: Estimated Lifetime Prevalence](image)

**Recognizing and Avoiding 5 Cognitive Traps**

i) Setting unrealistic standards for yourself  
ii) Negative “what if” thinking  
iii) Turning a single negative event into a catastrophe  
iv) Judging anything short of perfection to be a failure  
v) Demanding perfection in yourself and others

If happiness depends on these conditions, a stage is set for disappointment and depression.
Anxiety disorders all have unrealistic, irrational fears or anxieties of disabling intensity; frequent fearful thoughts about what might happen in the future.

Anxiety disorder is a blanket term covering several different forms of abnormal, pathological anxiety, fears, phobias. It describes nervous system disorders as irrational or illogical worry not based on fact.

Anxiety and fear are ubiquitous emotions. The terms anxiety and fear have specific scientific meanings, but common usage has made them interchangeable. For example, a phobia is a kind of anxiety that is also defined in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR) as a "persistent or irrational fear." Fear is defined as an emotional and physiological response to a recognized external threat.

Anxiety is an unpleasant emotional state, the sources of which are less readily identified. It is frequently accompanied by physiological symptoms that may lead to fatigue or even exhaustion. Because fear of recognized threats causes similar unpleasant mental and physical changes, patients sometimes use the terms fear and anxiety interchangeably.

Distinguishing among different anxiety disorders is important, since accurate diagnosis is more likely to result in effective treatment and a better prognosis.

10.1.1 Generalized Anxiety Disorder

People who are plagued with chronic worry for 6 months or more it may be caused by problems with finances, health, work, or ability to function socially. Affects twice as many women as men. Antidepressant drugs and cognitive and behavioral therapies may be helpful.

Symptoms include:
- Feeling tense, tired, and irritable
- Trembling, palpitations, sweating, dizziness, nausea, diarrhea

10.1.2 Panic Attacks

An episode of overwhelming anxiety, fear, or terror. About 2% of men and 5% of women in the U.S. Treatments include medication and psychotherapy..

Symptoms include
- A pounding heart
- Uncontrollable trembling or shaking
- Sensations of choking or smothering
- Feeling as if you are going to die
- Feeling as if you are “going crazy”
- The more catastrophic the belief, the more intense the panic
• Recurring panic attacks may be diagnosed with panic disorder
• Anxiety about the occurrence or consequences of future attacks
• Significant Health and Social Consequences
• Frequently visit doctors’ offices and emergency rooms
• Increased risk for abuse of alcohol and other drugs

10.1.3 Phobias

A phobia is an irrational, intense, persistent fear of certain situations, activities, things, or persons. The main symptom of this disorder is the excessive, unreasonable desire to avoid the feared subject. When the fear is beyond one’s control, or if the fear is interfering with daily life, then a diagnosis under one of the anxiety disorders can be made.

A persistent, irrational fear of some specific object, situation, or activity that poses little or no real danger. Phobics realize their fears are irrational, but feel compelled to avoid the feared situations or objects.

Life is planned around avoiding feared situations; they may not leave home unless accompanied by a friend, family member, or when severe, not even then. Leads to avoidance of places or situations where attack occurred; affects physical, psychological, social, occupational, and interpersonal and economic areas of life.

Women are four times more likely than men to be diagnosed; begins typically in early adult years with panic attacks.

Social Phobia

An irrational fear and avoidance of any social or performance situation in which one might embarrass or humiliate oneself in front of others by shaking, blushing, sweating, or appearing clumsy, foolish, or incompetent.

The most common type of anxiety disorder; may take the form of Performance Anxiety. One third only fear speaking in public; in extremes can affect performance at work, education, or restrict social life; many turn to alcohol or tranquilizers to reduce symptom’s affect.

Specific Phobia

Marked fear of a specific object or situation; a general label for any phobia other than agoraphobia or social phobia. When facing the phobic item or situation people experience intense anxiety even to the point of shaking or screaming; will go to great lengths to avoid the feared object or situation.

Phobic items include (ranked by frequency of occurrence)
• Situational phobias (elevators, airplanes, enclosed places, tunnels)
• Fear of natural environment (storms or water)
• Animal phobias (dogs, snakes, insects, or mice)
• Blood injection-injury phobia (fear of seeing blood or receiving an injection)
• Claustrophobia (closed spaces) and acrophobia (heights) most often treated by therapists

Agoraphobia: An intense fear of being in a situation from which escape is not possible or in which help would not be available if one experienced overwhelming anxiety or a panic attack.

Causes of Phobias

It is generally accepted that phobias arise from a combination of external events and internal predispositions. In a famous experiment, Martin Seligman used classical conditioning to establish phobias of snakes and flowers. The results of the experiment showed that it took far fewer shocks to create an adverse response to a picture of a snake than to a picture of a flower, leading to the conclusion that certain objects may have a genetic predisposition to being associated with fear.

Many specific phobias can be traced back to a specific triggering event, usually a traumatic experience at an early age. Social phobias and agoraphobia have more complex causes that are not entirely known at this time. It is believed that heredity, genetics, and brain chemistry combine with life-experiences to play a major role in the development of anxiety disorders and phobias.

Heredity is an important factor in the development of phobias. A family study of social phobia has demonstrated that the generalized form of this disorder (where the person is fearful in most types of social situations) is also familial in nature and etiologically distinct from other types of anxiety disorder.

May be caused by direct conditioning, modeling, or the transmission of information or traumatic childhood experience with the feared object or situation. Observational learning occurs when children who hear parents talk about a frightening encounter with a dog may develop a fear of dogs.

Treatment of Phobias

Principles of Learning

• Classical conditioning: Help patients associate pleasant emotions with feared items.
• Behavior Modification: Patients are reinforced for exposing themselves to fearful stimuli
• Modeling: Observing others who do not fear to the situation or object
Medication

Antidepressant drugs have been shown to be helpful.

10.1.4 Obsessive-Compulsive Disorder (OCD)

Obsessive-compulsive disorder (OCD) is a psychiatric anxiety disorder most commonly characterized by a subject's obsessive, distressing, intrusive thoughts and related compulsions (tasks or "rituals") which attempt to neutralize the obsessions. It is an anxiety disorder in which a person suffers from recurrent obsession or compulsions, or both.

The phrase "obsessive-compulsive" is often used in an offhand manner to describe someone who is meticulous or absorbed in a cause (see "anal retentive"). Such casual references should not be confused with obsessive-compulsive disorder; see clinomorphism.

It is also important to distinguish OCD from other types of anxiety, including the routine tension and stress that appear throughout life. Although these signs are often present in OCD, a person who shows signs of infatuation or fixation with a subject/object, or displays traits such as perfectionism, does not necessarily have OCD, a specific and well-defined condition.

To be diagnosed with obsessive-compulsive disorder, one must have either obsessions or compulsions alone, or obsessions and compulsions, according to the DSM-IV-TR diagnostic criteria. The Quick Reference to the diagnostic criteria from DSM-IV-TR (2000) describes these obsessions and compulsions, as follows:

Obsessions are defined by:

- 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.

- The thoughts, impulses, or images are not simply excessive worries about real-life problems.

- The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.

- The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind, and are not based in reality.

Obsessions are persistent, involuntary thoughts, images, or impulses that invade consciousness and cause great distress, for example:

- Contamination by germs
- Whether they performed a specific action
- Turning off the stove or locking the door
- Aggression
- Religion
- Sex
Compulsions are defined by:

- Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.

- The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

**Compulsions** are persistent, irresistible, and irrational urges to perform an act or ritual repeatedly, for example:

- Individuals know the act is senseless but cannot resist performing them without experiencing intolerable anxiety
- Anxiety is relieved only by doing the action
- Becomes a psychological problem only if:
- The person cannot resist performing it
- It is very time-consuming
- It interferes with normal activities and relationships with others

In addition to these criteria, at some point during the course of the disorder, the sufferer must realize that his/her obsessions or compulsions are unreasonable or excessive. Moreover, the obsessions or compulsions must be:

- time-consuming (taking up more than one hour per day),
- cause distress, or
- cause impairment in social, occupational, or school functioning.

OCD often causes feelings similar to those of depression. About 75% of OCD involves cleaning and checking. Sometimes reflects superstitious thinking that must be done to ward off danger. OCD occurs in 2-3% of U.S. population with fairly similar rates reported in Canada, Puerto Rico, Germany, Korea, and New Zealand.

**Predisposition**

- Early autoimmune diseases,
- Strep infections,
- Changes in the brain caused by infection
- Twin and family studies indicate genetic factors
- Genes affecting serotonin are suspected of causing OCD

**Treatment**

Behavioral treatment that combines exposure and response prevention may be the most effective approach to OCD. This involves having clients repeatedly expose themselves to stimuli of that will provoke their obsession and prevent them from engaging in their compulsive rituals.

Medications that affect the serotonin seem to be the primary class of medication that has good effects on OCD. These medications alter the functioning of the serotonin system such
as clomipramine (Anafranil) and fluoxetine (Prozac) appear to reduce the symptoms by 50 to 70 percent. The disadvantage is that relapse rates are generally high once the medication is discontinued.

Mood disorder is a condition whereby the prevailing emotional mood is distorted or inappropriate to the circumstances. They are disorders characterized by extreme and unwarranted disturbances in emotion or mood.

The two major types of mood disorders are depression (or unipolar depression) and bipolar disorder:

1. Depression (or unipolar depression), including subtypes:
   - Major depression
   - Major depression (recurrent)
   - Major depression with psychotic symptoms (psychotic depression)
   - Dysthymia
   - Postpartum depression

2. Bipolar disorder, a mood disorder formerly known as “manic depression” and described by alternating periods of mania and depression (and in some cases rapid cycling, mixed states, and psychotic symptoms). Subtypes include:
   - Bipolar I
   - Bipolar II
   - Cyclothymia

10.2.1 Culture, Gender, and Depression

In most countries rate of depression for females twice that for males, largely due to conflicting roles of wife, mother, lover, friend, etc. Boys twice as likely before puberty; after, females twice as likely; women more likely to have negative consequences from depression.
10.2.2 Major Depressive Disorder

Marked by feelings of great sadness, despair, and hopelessness as well as the loss of the ability to experience pleasure. Symptoms:

- Changes in appetite, weight, or sleep patterns
- Loss of energy
- Difficulty in thinking or concentrating
- Psychomotor disturbances
- Slowed body movements, reaction time, and speech or
- Constant movement, fidgeting, wringing of hands, and pacing
- Psychotic depression when severe
- Delusions or hallucinations

Major Depressive Disorder lasts 1 year after initial diagnosis. Generally, about 40% of patients are without symptoms, 40% are still suffering with the disorder and 20% are still depressed but not enough to warrant hospitalization. Slightly less than half of hospitalized patients are fully recovered.

Treatment

Many receive antidepressant drugs; studies reflect psychotherapy can be equally effective. 50-60% of patients will have a recurrence; recurrence greatest for females and when initial onset is before 15. May be frequent or infrequent, 20-35% of patients recurrence is chronic—lasting more than 2 years.

Medication, psychotherapy, social support, and exercise preventative. The types of medication that are used most frequently in the treatment of unipolar mood disorders fall into four general categories: selective serotonin reuptake inhibitors (SSRIs), tricyclics (TCAs), monoamine oxidase inhibitors (MAO-Is), and “other,” more recently developed drugs.

ACTIVITY

(a) Explain the different types of mood disorders and their symptoms.
10.2.3 Bipolar disorder

A mood disorder in which manic episodes alternate with periods of depression usually with relatively normal periods in between.

**Manic episode:**
- Excessive euphoria
- Inflated self-esteem
- Wild optimism
- Hyperactivity
- Temporarily lose touch with reality
- Frequently have delusions of grandeur along with euphoric highs
- May waste large sums of money on get-rich schemes
- Likely become irritable, hostile, enraged, or dangerous if stopped
- May be hospitalized to protect themselves from disastrous consequences

Afflicts ~ 1.2% of the population. Prevalence is equal between male and female. Onset during late adolescence or early adulthood. More than 90% have recurrences. About 50% within a year of recovery. Between 70-80% return to a state of emotional stability.

Mild cognitive deficits persist following manic episode. Many manage their disorder and lead normal lives with the aid of medication. Psychotherapy helps cope with stress of chronic mental illness.

10.2.4 Causes of Mood Disorders

**Biological factors**

Heredity and abnormal brain structure and chemistry.

Abnormal levels of serotonin linked to depression and suicide; production, transport, and reuptake patterns of dopamine, GABA, and norepinephrine different than “normal” people; neurotransmitter abnormalities may reflect genetic variations.

Heritability of depressive disorder is 70%, environment 30%; 50% of identical twins of bipolar and 7% of fraternal twins diagnosed with bipolar disorder; biological relatives of bipolar disorder sufferers are at increased risk for a number of other mental disorders.

**Cognitive Factors**

Depressed individual view themselves, the world, and future in a negative way. Interactions are seen as a series of burdens and obstacles that end in failure.

Depressed individuals view themselves as failures and may think:
- “everything turns out wrong”
- “I never win” or “it’s no use”
- “Things will never get better”
**Life Stressors**

Vast majority of first depression episodes occur after major life stress. Women are more likely to experience a severe negative life event just prior to the onset of depression. Recurrence of depression in people with biological predisposition often occurs without major life stressor

**10.2.5 Suicide and Race, Gender, and Age**

Mood disorders, schizophrenia, and substance abuse are major risk factors for suicide in all age groups. Suicide risk increases when exposed to troubling life stressor.

Suicidal behavior runs in families. Women are at more risk for suicide than men. Older people are at far greater risk than younger ones.

![Figure 10.4: Suicide rates according to age group.](image)

Almost 90% of individuals who commit suicide leave clues, such as:

- Verbally – “you won’t be seeing me again”
- Behavioral – giving away most valued possessions
- Taking unnecessary risks
- Showing personality changes
- Losing interest in favorite activities

Warning signs should be taken seriously; encourage them to get professional help or call 24-hour hotline.

**ACTIVITY 10.2**

(a) Explain the causal factors of mood disorder.
(b) Who is at highest risk for suicide?
10.3 SCHIZOPHRENIA

Schizophrenia is a severe psychological disorder characterized by loss of contact with reality, hallucinations, delusions, inappropriate or flat affect, some disturbance in thinking, social withdrawal, and/or other bizarre behavior.

It is a psychiatric diagnosis that describes a mental illness characterized by impairments in the perception or expression of reality, most commonly manifesting as auditory hallucinations, paranoid or bizarre delusions or disorganized speech and dysfunctional thinking.

The disorder is primarily thought to affect cognition. It also usually contributes to chronic problems with behavior and emotion. People diagnosed with schizophrenia are likely to be diagnosed with comorbid conditions, including clinical depression and anxiety disorders; the lifetime prevalence of substance abuse is typically around 40%.

Positive Symptoms

- Hallucinations
- Delusions
- Derailment
- Inappropriate affect

Negative Symptoms

- Social Withdrawal
- Apathy
- Loss of motivation
- Lack of goal-directed behavior
- Very limited speech
- Slow movements
- Poor hygiene
- Poor problem-solving
- Distorted sense of time

Social problems, such as long-term unemployment, poverty and homelessness, are common and life expectancy is decreased; the average life expectancy of people with the disorder is 10 to 12 years less than those without, owing to increased physical health problems and a high suicide rate.

Onset of symptoms typically occurs in young adulthood, with approximately 0.4–0.6% of the population affected. Diagnosis is based on the patient’s self-reported experiences and observed behavior. No laboratory test for schizophrenia currently exists.

Studies suggest that genetics, early environment, neurobiology and psychological and social processes are important contributory factors. Current psychiatric research is focused on the role of neurobiology, but no single organic cause has been found. Increased dopaminergic
activity in the mesolimbic pathway of the brain is a consistent finding. Due to the many possible combinations of symptoms, there is debate about whether the diagnosis represents a single disorder or a number of discrete syndromes.

For this reason, Eugen Bleuler termed the disease the *schizophrenias* (plural) when he coined the name. Despite its etymology, schizophrenia is not synonymous with dissociative identity disorder, previously known as multiple personality disorder or split personality; in popular culture the two are often confused.

The main treatment is pharmacotherapy with antipsychotic medications; these primarily work by suppressing dopamine activity. Dosages of antipsychotics are generally lower than in the early decades of their use. Psychotherapy, vocational and social rehabilitation are also important. In more serious cases—where there is risk to self and others—involuntary hospitalization may be necessary, though hospital stays are less frequent and for shorter periods than they were in previous years.

### 10.3.1 Brain Abnormalities in Schizophrenia

Several abnormalities in brain structure and function have been found.

- Low levels of neural activity in the frontal lobes
- Defects in neural circuitry of the cerebral cortex and limbic system
- Reduced volume in hippocampus, amygdala, thalamus, and frontal lobes
- Abnormal lateralization of brain functions slow communications between left and right hemispheres

Abnormal dopamine activity is common which may result from cocaine abuse. Medication effective in reducing symptoms of schizophrenia block dopamine action. One third who take these medications do not show improvement.

### 10.3.2 Types of Schizophrenia

**Paranoid Schizophrenia**

- Characterized by delusions of grandeur or persecution
- Convinced they have an identity other than their own or that they possess great ability or talent
- Often show exaggerated anger and suspiciousness
- Feel they are being harassed or threatened
- May become violent to defend themselves against imagined persecutors

Behavior is not as disturbed as other types. The chance for recovery is better

**Disorganized Schizophrenia**

The most serious type; results in the most severe disintegration of personality; poorest chance of recovery.
• Extreme social withdrawal
• Hallucinations
• Delusions
• Silliness
• Inappropriate laughter
• Grotesque mannerisms
• Show flat or inappropriate affect
• Frequently incoherent
• May exhibit obscene behavior
• May swallow almost any kind of object or material

Catatonic Schizophrenia

• Complete stillness or stupor
• Great excitement or agitation
• Frequently alternate rapidly between the two
• May assume an unusual posture
• Remain in the pose for long periods of time

Undifferentiated Schizophrenia

A catchall term used when schizophrenic symptoms either do not conform to the criteria of any one type of schizophrenia or conform to more than one type

10.3.3 Risk Factors in Schizophrenia

• Genetic factors play a major role; it develops when both a genetic predisposition and more stress than a person can handle are present
• Environmental factors increase risk
• Birth trauma, virus, malnutrition, head injury, etc.

Figure 10.5: Chances of developing schizophrenia according to relationship
Somatoform disorders are characterized by physical symptoms that mimic disease or injury for which there is no identifiable physical cause or physical symptoms such as pain, nausea, depression, and dizziness. These physical symptoms are present that are due to psychological causes rather than any known medical condition. People with somatoform disorders are not faking illness to avoid work or other activities. Somatoform disorders are physical symptoms which present as part of a general medical condition. However, no general medical condition, other mental disorder, or substance is adequately diagnosed.

The complaints are serious enough to cause significant emotional distress and impairment of social and/or occupational functioning. An inadequate diagnosis might be the result of inconclusive or faulty test results or in some cases intentional malpractice in which a caregiver deliberately mishandles a patient's health care to derive some benefits.

A diagnosis of a somatoform disorder implies that psychological factors are a large contributor to the symptoms' onset, severity and duration. It is important to note that somatoform disorders are not the result of conscious malingering or factitious disorders.

### 10.4.1 Hypochondriasis

Persons are preoccupied with their health and fear that their physical symptoms are a sign of some serious disease despite reassurance from doctors to the contrary; not convinced when medical examination reveals no problem.

Symptoms are not consistent with known physical disorders; may “doctor shop” seeking confirmation of their worst fears. It is not easily treated with a poor chance of recovery.
10.4.2 Conversion Disorder

A person suffers a loss of motor or sensory functioning in some part of the body. The loss has no physical cause but solves some psychological problem.

May become blind, deaf, unable to speak, or paralysis in some part of the body; Freud believed it is an unconscious process to help solve an unconscious sexual or aggressive conflict.

10.4.3 Dissociative Disorders

Disorders which, under unbearable stress, consciousness becomes dissociated from a person’s identity or her/his memories of important personal events, or both.

_Dissociative Amnesia_

A complete or partial loss of the ability to recall personal information or identify past experiences which cannot be attributed to forgetfulness or substance abuse.

Often caused by traumatic experience or a situation creating unbearable anxiety causing the person to escape by “forgetting”. However, they do not forget how to carry out routine tasks and basic personality remains intact.

_Dissociative fugue_

A complete loss of memory of one’s entire identity. The person may assume a new identity that is more outgoing and uninhibited than their former identity. Usually a reaction to a severe psychological stress.

May last hours, days, or months and May have no memory of initiating stressor or events during the episode.

_Dissociative Identity Disorder (DID)_

Two or more distinct, unique personalities occur in the same person; severe memory disruption concerning personal information about the other personalities. In 50% of cases there are more than 10 different personalities.

Change usually occurs during sudden and during stress; host personality is one in charge of body most of the time.

Alter personalities may differ radically in intelligence, speech, accent, vocabulary, posture, body language, hairstyle, taste in clothes, manners, handwriting, and sexual orientation. 80% of cases host personality doesn’t know alter personalities; alter personalities have varying levels of awareness of each other.

Lost time: periods with no memory when in alter personality
Usually begins in childhood, rarely in adolescence; 90% are women, 95% history of severe physical and/or sexual abuse.

**ACTIVITY 10.4**

(a) What are somatoform disorders?
(b) Explain the different kinds of dissociative disorders.

### 10.5 SEXUAL DISORDERS

Disorders with a sexual basis that are destructive, guilt, or anxiety producing, compulsive, or a cause of discomfort or harm to one or both parities involved.

**Sexual dysfunction** or **sexual malfunction** is difficulty during any stage of the sexual act (which includes desire, arousal, orgasm, and resolution) that prevents the individual or couple from enjoying sexual activity.

Emotional factors affecting sex include both interpersonal problems (such as marital/relationship problems, or lack of trust and open communication between partners) and psychological problems within the individual (depression, sexual fears or guilt, past sexual trauma, sexual disorders, and so on).

Physical factors include:
- drugs (alcohol, nicotine, narcotics, stimulants, antihypertensives, antihistamines, and some psychotherapeutic drugs);
- injuries to the back, problems with an enlarged prostate gland, problems with blood supply,
- nerve damage (as in spinal cord injuries); or disease (diabetic neuropathy, multiple sclerosis, tumors, and, rarely, tertiary syphilis);
- failure of various organ systems (such as the heart and lungs); endocrine disorders (thyroid, pituitary, or adrenal gland problems);
- hormonal deficiencies (low testosterone, estrogen, or androgens); and
- some birth defects.

The sexually dimorphic nucleus starts the same in males and females:
- First few days after birth, area grows rapidly in males
- Growth triggered by estradiol, aromatized from testosterone
- Growth complete by 4 days after birth (castration no longer has effect)
- Size of the sexually dimorphic nucleus correlated with the rat’s testosterone levels and sexual behavior
- Lesions to the sexually dimorphic nucleus in adult rats—only slight effects dimorphic nuclei in the human hypothalamus
The hypothalamus and male sexual behavior

Bilateral medial preoptic area lesions:
- abolish male behaviors (mounting) in both sexes
- electrical stimulation or implants of testosterone into the medial preoptic area—induces copulatory behaviors.
- Medial preoptic area appears to underlie sexual motivation.
- Lateral tegmental field receives projections from the medial preoptic area and mediates copulatory behavior in rats.
- Neuropharmacological approaches—dopamine and endogenous opioids increase in the medial preoptic area before and during copulation.
- Copulation reduces androgen receptors in medial preoptic area.

The hypothalamus and female sexual behavior

- Ventromedial nucleus (VMN) are critical for female sexual behavior.
- Estradiol primes VMN by increasing progesterone receptors.
- Estradiol and progesterone injected into the VMN induces estrus in ovariectomized rats.
- Periaqueductal gray (PAG) is also involved.

10.5.1 Sexual Dysfunctions

Sexual dysfunction disorders are generally classified into four categories:
1. sexual desire disorders,
2. sexual arousal disorders,
3. orgasm disorders, and
4. sexual pain disorders.

Sexual desire disorders or decreased libido can be caused by a decrease in normal estrogen (in women) or testosterone (in both men and women) production. Other causes may be aging, fatigue, pregnancy, medications (such as the SSRIs) or psychiatric conditions, such as depression and anxiety. Loss of libido from SSRIs usually reverses after SSRIs are discontinued, but in some cases it does not.

Sexual arousal disorders were previously known as frigidity in women and impotence in men, though these have now been replaced with less judgmental terms. Impotence is now known as erectile dysfunction, and frigidity has been replaced with a number of terms describing specific problems with, for example, desire or arousal.

For both men and women, these conditions can manifest as an aversion to, and avoidance of, sexual contact with a partner. In men, there may be partial or complete failure to attain or maintain an erection, or a lack of sexual excitement and pleasure in sexual activity.

Male Erectile Disorder – Persistent or recurrent inability to attain or to maintain until the completion of the sexual activity an adequate erection.
**Female Orgasmic Disorder** – Persistent of recurrent delay in, or absence of, orgasm following a normal sexual excitement phase. Diagnosis is made based on clinicians judgment that the woman’s orgasmic capacity is less than would be reasonable for her age, sexual experience, and the adequacy of sexual stimulation she receives.

There may be medical causes to these disorders, such as decreased blood flow or lack of vaginal lubrication. Chronic disease can also contribute, as well as the nature of the relationship between the partners. As the success of sildenafil (Viagra) attests, most erectile disorders in men are primarily physical, not psychological conditions.

Orgasm disorders are a persistent delay or absence of orgasm following a normal sexual excitement phase. The disorder can occur in both women and men. Again, the SSRI antidepressants are frequent culprits -- these can delay the achievement of orgasm or eliminate it entirely.

Sexual pain disorders affect women almost exclusively and are known as dyspareunia (painful intercourse) and vaginisms (an involuntary spasm of the muscles of the vaginal wall that interferes with intercourse). Dyspareunia may be caused by insufficient lubrication (vaginal dryness) in women.

Poor lubrication may result from insufficient excitement and stimulation, or from hormonal changes caused by menopause, pregnancy, or breast-feeding. Irritation from contraceptive creams and foams can also cause dryness, as can fear and anxiety about sex.

It is unclear exactly what causes vaginismus, but it is thought that past sexual trauma (such as rape or abuse) may play a role. Another female sexual pain disorder is called vulvodynia or vulvar vestibulitis. In this condition, women experience burning pain during sex which seems to be related to problems with the skin in the vulvar and vaginal areas. The cause is unknown.

Sexual dysfunctions are more common in the early adult years, with the majority of people seeking care for such conditions during their late twenties through thirties. The incidence increases again in the geriatric population, typically with gradual onset of symptoms that are associated most commonly with medical causes of sexual dysfunction.

Sexual dysfunction is more common in people who abuse alcohol and drugs. It is also more likely in people suffering from diabetes and degenerative neurological disorders. Ongoing psychological problems, difficulty maintaining relationships or chronic disharmony with the current sexual partner can also interfere with sexual function.

**Treatment**

Drug treatments have been highly successful for men and women, e.g. Viagra (men) and DHEA (women).

Individual and couples therapy are required to improve intimate relationships.
10.5.2 Paraphilias

a) Recurrent sexual urges, fantasies, or behaviors involving:
   • Children or non-consenting persons
   • Nonhumans, objects, or
   • The suffering or humiliation of the individual or his or her partner

b) A person must experience considerable psychological distress or impairment in functioning in an important area of life.

10.5.3 Gender Identity Disorder

Gender identity disorder is a problem in accepting one’s identity as male or female. People with gender identity disorder show a strong preference for the clothes, games, pastimes, and playmates of the opposite sex. It goes far beyond cross-gender play of other children. They often express the desire to be the opposite sex. As adults, they may feel so strongly about their preference to be the opposite sex that sex-reassignment surgery is done.

Types of transsexualism:
   • Surgical sexual reassignment—surgery to change sex
   • Male-to-female change—good results are obtained
   • Independence of sexual orientation and sexual identity
   • Sexual attraction, sexual identity, and body type unrelated

Genes strongly influence development (twin studies).

ACTIVITY 10.4

Discuss the activational effects of gonad hormones on the sexual behavior of women and men. The popular press and many scientific sources have expressed concern that estrogen like compounds in the environment may be changing how human beings mature. Here are two Web Links, one on each side of the issue, with some good information:

- Web Link 10.19 Environmental Estrogens
  http://neuroendo.org.uk/index.php/content/view/33/11/

- Web Link 10.20 Endocrine Disruptors
  http://www.sph.emory.edu/PEHSU/html/exposures/endocrine.htm
SELF TEST

1. When anxiety disrupts normal behavioral functioning, it is generally referred to as ______________________.

2. Disorders characterized by recurring uncontrollable anxiety-producing thoughts and impulses are classified as ________ disorders.

3. A disorder of psychological function sufficiently severe to require treatment by a psychiatrist is a ________ disorder.

4. Schizophrenia typically begins in ____________________.

5. Hallucinations associated with schizophrenia often take the form of ____________________.

6. Studies of monozygotic and dizygotic twins suggest that schizophrenia ____________________.

7. Symptoms such as blunt affect, catatonia, and poverty of speech are ____________________.

8. The diathesis-stress theory of depression is that depression is caused by ____________________.

9. Depressed patients who do not experience periods of mania are said to suffer from ________ depression.

10. Lithium has often been used as a treatment for ____________________.

11. Sometimes under tremendous stress, a person disconnects from his/her consciousness and becomes parts versus one whole. This category of disorders is ____________________.

12. ______ occurs when an individual suddenly moves away and assumes a new identity, seemingly unaware of the previous one.
SELF TEST

13. _______ is the belief that natural phenomena such as winds and tides
An intense fear of being humiliated or criticized by others in social
situations is the basic idea behind _______.

14. An irresistible urge to perform a behavior or action that serves to reduce
anxiety is referred to as a(n) _______.

15. Extreme sadness, despair, a feeling of slowing down, and problems in
eating and sleeping characterize which of the following disorders?

16. Bizarre thinking and behaviors in addition to disturbances in perception,
emotion, and social interaction suggest the presence of

17. _______ is diagnosed when an individual has an apparent loss of
sensory or motor function with no known physical cause.

18. Memory loss, usually after a highly stressful event, is often referred to as

19. Michael has felt for years that he was born into the wrong body.
Although he is physically amale, he truly believes himself to be female
inside. As a child, he wanted to play with typical girl toys and engaged
in many of the same behaviors in which little girls typically engage. As
an adult, he has grown more and more uncomfortable in his own skin,
to the point that he is becoming depressed.

20. Persistent, recurrent, and distressing problems involving sexual desire,
sexual arousal or pleasure associated with sex or orgasm are considered
__________.
Suggested Text and References

Required Reading:


Suggested Readings


Suggested Web Sites

Schizophrenia
http://www.schizophrenai.com/

Dana Brain Web
http://www.dana.org/brainweb/

All About Depression
http://depression.mentalhelp.net/

The Search for Novel Antipsychotic Drugs
http://salmon.psy.plym.ac.uk/year2/schizo1.htm

Generalized Anxiety Disorder
Self-check

Answers:

1. an anxiety disorder.
2. obsessive-compulsive
3. psychiatric
4. adolescence or early adulthood.
5. voices.
6. is influenced by genetic factors.
7. negative symptoms of schizophrenia.
8. the interaction of a genetic susceptibility and stress
9. unipolar
10. bipolar affective disorder.
11. dissociative disorders
12. Dissociative fugue
13. social phobia
14. compulsion
15. major depressive disorder.
16. schizophrenia..
17. Conversion disorder.
18. dissociative amnesia.
19. gender identity disorder
20. sexual dysfunctions.