Psychodiagnosis I
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CE Hours: 2

Course Introduction

This online continuing education course, Psychodiagnosis, is presented in two separate volumes (continuing education quizzes for contact hours are offered separately). Volume One presents information regarding the professional and ethical use of the DSM-IV-TR, diagnosing children’s mental disorders, and information on cognitive disorders. Substance abuse, psychoses, and mood disorders also are highlighted. Volume Two of Psychodiagnosis focuses on anxiety disorders, somatoform disorders, and dissociative disorders. Other topics include sexual dysfunctions, impulse-control disorders, eating disorders, and sleep disorders. Personality disorders and other areas for clinical attention round out Volumes One and Two of Psychodiagnosis.

Learning Objectives

Upon completion of this course, you will

- understand the basic issues in the process of diagnosing children
- understand general information regarding various mental disorders including cognitive disorders, psychoses, mood and anxiety disorders, sexual dysfunctions, and personality disorders

Course Content

Article: Psychodiagnosis I: Using the DSM-IV-TR in Clinical Mental Health Counseling, pages 3-47

Using the DSM-IV-TR in Clinical Mental Health Counseling

J. Scott Hinkle

It is important for mental health counselors (MHCs) to be able to effectively and wisely use the Diagnostic and Statistical Manual of Mental Disorders (DSM). A DSM diagnosis is only the first step in evaluating a client, and it does not necessarily equal prognosis. Information regarding diagnosis is needed for effective treatment planning, clinical care, communication among practitioners, and systematic research to enhance the knowledge of mental disorders. Essentially, the diagnosis is the first step in the complicated process of treating the client (Ninan, 1990). Ninan (1990) has indicated that on a basic level “a diagnostic system should serve a number of functions: to prevent confusion in communication about patients with the same constellation of symptoms within the framework of individual variations; to help define a homogenous group of patients for clinical research studies; to classify a group of patients for the definition of treatment issues in a clinical setting; and to have some predictive capacity” (p. 13).

Despite its limitations, the DSM system meets these criteria and is currently the best system we have (Ninan, 1990). The counseling profession has clearly recognized the importance of the DSM system by including it in counselor mental health education program instruction and licensure examinations. Although there are criticisms associated with the development and use of the DSM (e.g., Kutchins & Kirk, 1997), the manual has served an important role in mental health counseling for nearly twenty years.

Even under the best of circumstances, using diagnostic labels remains a troubling issue for many counselors. It is their contention that labels cause the dehumanization of clients which may lead counselors to devalue clients, to discredit their concerns, and to disengage from authentic interaction (Benson, Long, & Sporakowski, 1992). Moreover, Carlson, Hinkle, and Sperry (1993) have indicated that, “counselors have expressed the concern that they will be losing some of their hearts or possibly selling their souls by incorporating diagnosis into their practice” (p. 308). Despite this, diagnosis is required for third party reimbursement (Cowger, Hinkle, DeRidder, & Erk, 1991).

Although criticisms regarding the use of the DSM have been made, in reality counselors have been working with people experiencing disorders described in the DSM for decades. For example, depression and anxiety are the most common clinical symptoms associated with personal problems. More specifically, alcohol and drug issues among adults, adolescents, and children are treated everyday by counselors in mental health clinics, colleges, universities, and public schools.

In the early 1980s the DSM-III achieved unexpected recognition (Spitzer, 1985). This success was unanticipated by its supporters because DSM-I and DSM-II (APA, 1952, 1968) had been criticized by clinicians who maintained that these earlier versions were unscientific and encouraged negative labeling. In contrast, the developers of DSM-III claimed that their edition was unbiased and much more scientific (Spitzer, 1980).

Even though many of the earlier problems persisted, reservations about the manual were offset by the increasing demand that psychotherapists report a DSM diagnosis for clients who qualify for reimbursement for treatment from private insurers or from governmental programs (Kutchins & Kirk, 1989).
Utilization of the DSM within the counseling profession is not without controversy. Although literature concerning the use of the DSM in mental health counselor education programs is limited, assigning a psychodiagnosis to a client is uncomfortable for many counselors. The disadvantages associated with using the DSM have included the promotion of a mechanistic or “cookbook” approach to mental disorder assessment, a false impression that the understanding of mental disorders is more advanced than is actually the case; and an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more comprehensive understanding of the client’s problems (Hinkle, 1994; Williams, Spitzer, & Skodol, 1985, 1986). It also has been said that the DSM focuses too much attention on surface phenomena at the expense of clinical manifestations and human development (Vaillant, 1984).

At the same time, advantages to implementing the DSM have included the development of a common language for discussing diagnoses, an increase in the utilization of behavioral definitions, the advancement of prescriptive treatments, and the facilitation of the overall learning of psychopathology. The DSM undergoes periodic revisions, which add to the arguments concerning advantages and disadvantages.

**Conclusion**

MHCs have used the DSM in the past, use it today, and will use it in the future. An understanding of this diagnostic system and its vast implications in counseling, both positive and negative, will be imperative to the effective and ethical delivery of professional community mental health counseling services (Hinkle, 1994).

**References**


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The profession of counseling is growing rapidly as reflected by the proliferation of professional community mental health counseling graduate programs. Graduates of these programs are providing counseling services in mental health centers, psychiatric hospitals, employee assistance programs, and various other community settings. At the foundation of effective mental health care is problem conceptualization and treatment planning which rely on the establishment of a valid diagnosis. This has caused an increase in the number of graduate community mental health counseling programs requiring course work in abnormal behavior, psychopathology, and psychodiagnosis. As a result, utilization of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR) American Psychiatric Association (APA, 2000) also has been dramatically increased in counselor education training. Skill in its use is undoubtedly necessary when assessing clients who seek services in community mental health settings.

Utilization of the DSM-IV-TR within the counseling profession is not, however, without controversy. Assigning a diagnosis to a client is uncomfortable for many counselors. The disadvantages associated with using the DSM have included the promotion of a mechanistic approach to mental disorder assessment, the false impression that the understanding of mental disorders is more advanced than is actually the case, and an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more in-depth understanding of the client’s problems including human development. Wakefield (1992) has recently argued that the DSM concept of mental disorder would better serve people if it were referred to as a harmful dysfunction. He has based this on numerous citations that have suggested psychodiagnosis is used to control or stigmatize behavior that is actually more socially undesirable than disordered.

Conversely, advantages to implementing the DSM have included the development of a common language for discussing diagnoses, an increase in attention to behaviors, and facilitation of the overall learning of psychopathology. Seligman (1990) has indicated that knowledge of diagnosis is important for counselors so that they may provide a diagnosis for clients with insurance coverage and inform clients if their counseling will be covered by medical insurance. In addition, a DSM diagnosis assists with accountability and record keeping, treatment planning, communication with other helping professionals, and identification of clients with issues beyond areas of expertise.

**Major Psychodiagnostic Features of the DSM-IV-TR**

According to the DSM-IV-TR, mental disorders are conceptualized as clinically significant behavioral or psychological syndromes or patterns that occur in a person and are associated with distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, the syndrome or pattern must not be an expectable response to a particular event (APA, 2000).

Although the DSM system can be difficult to interpret for those with limited clinical experience or personal familiarity with mental disorders, it is relatively easy for experienced counselors to learn. Each DSM-IV-TR diagnosis contains specific diagnostic criteria, the essential features and clinical information associated with the disorder, as well as differential diagnostic considerations. Information concerning diagnostic and associated
features, culture, age, and gender characteristics, prevalence, incidence, course and complications of the disorder, familial pattern, and differential diagnosis are included. Many diagnoses require symptom severity ratings (e.g., mild, moderate, or severe) and information about the current state of the problem (e.g., partial or full remission).

The DSM-IV-TR contains eighteen categories of mental disorders. Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence focuses on developmental disorders and other childhood difficulties. Delirium, Dementia, Amnestic and Other Cognitive Disorders include Alzheimer’s conditions and Vascular Dementia. Mental Disorders Due to a General Medical Condition include anxiety and mood difficulties as well as personality change due to physical complications. Substance Related Disorders consist of drug and alcohol abuse and dependence. Schizophrenia and Other Psychotic Disorders are a continuum of difficulties that include lack of contact with reality as well as Delusional Disorders. Mood Disorders and Anxiety Disorders, including Major Depression and Posttraumatic Stress Disorder are featured diagnoses often used by counselors. Somatoform Disorders, Factitious Disorders, Dissociative Disorders, Sexual and Gender Identity Disorders, Eating Disorders, Sleep Disorders, Impulse Control Disorders, Adjustment Disorders, and Personality Disorders are among the other diagnostic categories in the DSM-IV-TR. In addition, several lesser disorders referred to as V Codes are included (e.g., Parent-Child Relational Problem, Partner Relational Problem, Bereavement, and Occupational Problem). Due to the V Codes’ “minor status,” they are typically not covered by third party payers.

**The Multiaxial System**

Diagnoses in the DSM-IV-TR are coded by the multiaxial system which incorporates five axes. All diagnoses except for Personality Disorders and Mental Retardation are coded on Axis I. Only Personality Disorders and Mental Retardation are coded on Axis II. Axis III is for physical disorders and conditions. Axes IV and V represent Severity of Psychosocial and Environmental Problems and Global Assessment of Functioning (GAF), respectively, and are used for treatment planning and prognosticating. For example, a full multiaxial diagnosis would be presented as:

- **AXIS I:** 309.00 Adjustment Disorder with Depressed Mood V61.12 Partner Relational Problem
- **AXIS II:** 799.90 Diagnosis deferred on Axis II
- **AXIS III:** None
- **AXIS IV:** Change of jobs
- **AXIS V:** GAF=66 (highest past year)

In DSM-IV-TR, the multi-axial diagnosis is optional. When considering a DSM-IV diagnosis, the frequency, intensity, and duration of symptoms as well as premorbid functioning must be addressed.

**Sociocultural Implications**

Professional counselors utilizing DSM-IV-TR diagnoses wield sizeable power that can be interpreted as oppressive to some groups of people. Third party interests (i.e., insurance carriers) also may bring nonscientific values into the diagnostic process. An accurate psychodiagnosis depends on ethnocultural and linguistic sensitivity (Malgady, Rogler & Constantino, 1987). Clients of lower socioeconomic class may experience, define, and manifest mental disorders differently from middle- and upper-class clients. Moreover, the DSM’s lack of focus on the problematic features of a social context may be perpetuating the oppression of certain groups of people (e.g., women). Gender and race of clinician also have been found to impact an accurate
psychodiagnosis (Loring & Powell, 1988). Counselors using the DSM-IV-TR will need to be keenly aware of the implications associated with its use as well as the impact a diagnosis may have on a client’s treatment – within and outside of the counseling process. In conclusion, the DSM-IV-TR is not the only psychodiagnostic nomenclature in existence, but it is the most popular and is here to stay. Counselors have utilized it in a professional manner in the past, use the DSM-IV today, and will use the “DSM-V” in the future. An up-to-date understanding of this diagnostic system and its vast implications in counseling will be imperative to the effective and ethical delivery of professional community mental health counseling services.

References


Diagnosing Children’s Mental Disorders
Using the DSM-IV-TR

Thomas H. Hohenshil

Diagnosis of children’s mental disorders is a process which often involves several mental health professionals, as well as parents, teachers, and others who have significant knowledge of the child involved. The process may take place in a mental health agency, private practice setting, hospital, school, or some combination of these settings. Although some clinicians use the terms testing, assessment, and diagnosis interchangeably, there are some significant differences which are important to note. Assessment is the process of collecting information for use in the diagnostic process and can involve such sources as standardized tests, interviews, questionnaires, checklists, behavioral observations, projective tests, and reports (medical, etc.) by significant others. Tests, then, are only one of several ways to collect assessment information to use in the diagnostic process. Diagnosis, on the other hand, is the meaning that is derived from assessment information using some type of mental health classification system. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000) is the classification system used in mental health settings. Diagnosis involves a comparison, or matching, of the child’s symptoms with lists of DSM-IV-TR diagnostic criteria. If the symptoms meet or exceed the criteria, then a diagnosis is made (Hohenshil, 1995).

The Diagnostic and Treatment Process

In practice, the diagnostic and treatment processes are interdependent and interact through the following six steps:

Step 1.
Referral: Since children normally do not self-refer, someone else usually refers the child. This may be the parent(s), medical personnel, social services, school personnel, or the court system. Although some elementary school children refer themselves through elementary school counseling programs, it is a general rule that the younger the child the lower the probability of self-referral. Preschool children are almost always referred by parents, social services, or medical personnel. As noted later in this digest, this can be a problem in both diagnosis and treatment processes.

Step 2.
Symptom Identification: Identification of the child’s symptoms is a critical part of the diagnostic process since the DSM-IV-TR is highly dependent upon behavioral symptoms. Information about number, type, duration, and severity of symptoms is developed from a variety of sources. The most frequently used techniques are semistructured child diagnostic interviews, mental status examinations, interviews with significant others (parents, teachers, siblings, peers, etc.), behavioral observation, medical and social reports, psychological testing, and educational records.

Step 3.
Diagnosis: Diagnosis is a comparison of the symptoms the child exhibits with the diagnostic criteria for the mental disorders included in the DSM-IV-TR. A DSM-IV-TR diagnosis also requires that the symptoms be considerably in excess of those expected from other children of a similar developmental age. The degree of symptom severity is important because most children have at least some of the symptoms listed in the DSMIV-TR in various degrees. The DSM-IV-TR requires that one or more of the following “severity” criteria must
be met in order to diagnose a mental disorder: significant distress must be present in the child; or there must be significant impairment of educational, occupational, or social functioning; or the symptoms must cause significantly increased risk or loss of freedom. In practice, children with diagnosable mental disorders usually meet more than one of the severity criteria.

**Step 4.**
Treatment Planning: Effective treatment planning is highly dependent upon accurate diagnoses because the therapeutic techniques selected are determined by the type of mental disorder diagnosed. Research on differential therapies is relatively new; however, we are at a point where it is possible to determine the specific therapeutic techniques that are effective with most of the children’s mental disorders. The treatment plan normally includes a description of the disorder, both short- and long-term treatment objectives, interventions to be used, and the prognosis.

**Step 5.**
Treatment: The treatment techniques should follow the course outlined in the treatment plan. The techniques, frequency of treatment, and the type or orientation of the clinician are obviously important factors. After the conclusion of successful treatment, it may be necessary to change the diagnosis, for the child’s symptoms may be in remission. Or, other disorders might become more evident as treatment progresses, and additional diagnoses may need to be made. In any event, there is often a fluid nature to the diagnostic and treatment processes where neither can be considered independent of the other.

**Step 6.**
Follow-up: This step is important in determining whether the treatment is effective and if other counseling techniques may be helpful. Follow-up to successful treatment also is important to determine if the symptoms remain in remission (Hohenshil, 1995).

**Special Problems Diagnosing Children**
The DSM-IV-TR has a section which includes mental disorders that are usually first diagnosed in infancy, childhood, or adolescence. Some of the most frequently diagnosed children’s disorders are Mental Retardation, Learning Disorders, Attention Deficit Hyperactivity Disorder, Conduct Disorder, Autism, Elimination Disorders, and Separation Anxiety. It is important to note that most of the disorders included in other sections of the DSM-IV-TR can also be diagnosed in children and adolescents, including Mood Disorders, Anxiety Disorders, Substance-Related Disorders, Psychotic Disorders, Adjustment Disorders, Sexual and Gender Identity Disorders, and Sleep Disorders (American Psychiatric Association, 2000; Hohenshil, 1994). In fact, adolescents can be diagnosed with practically any of the disorders included in the DSM-IV-TR. Due to a number of factors, it is frequently more difficult to diagnose children than adults, and the younger the child the more tenuous the diagnosis. The fact that children do not normally self-refer can cause a problem of motivation. Persons who self-refer are more cooperative in the diagnostic process and more likely to make progress in treatment. Also, children who are referred by others are frequently not well-prepared by the referring party, and thus do not understand why they are being seen by a mental health counselor although they are sure that it is not because things are going well for them. A second problem is that young children have limited language facility which requires more inferences by the clinician; and the younger the child, the more language is a problem. Even if a young child uses many of the same words as adults, the meaning ascribed to them may be quite different. A third problem in diagnosing children is that significant others (e.g., parents, teachers, etc.) often provide a major part of the information about the child’s behavior. The clinician then has to determine the validity of the adult’s observations of the child’s behavior; in other words, is the parent or teacher a reliable
observer of the child’s behavior? Most experienced clinicians have seen children where it is strongly suspected
that the problem resides more with the parent than with the child. Due to the problems noted here, the
diagnoses of children are simply less reliable because clinicians have to make more inferences about the child’s
behavior and emotional status while arriving at a diagnosis (Hohenshil, 1995; Sattler, 1988).

Conclusion
Diagnosing children’s mental disorders presents an interesting challenge to most clinicians. Psychopathology
research clearly suggests that children should not be considered as just “little adults” in the diagnostic
and treatment process. Over the last 40 years, testing instruments, semi-structured interview procedures,
and observational techniques have been developed to reflect the unique nature of children’s language and
psychological development. The DSM series also has focused significant attention on the disorders of children,
and each revision has resulted in a refinement of the diagnostic criteria. The current DSM-IV-TR probably
reflects more changes in the section for children than in any other section. The result is more clearly defined
behavioral criteria and more accurate diagnoses. However, due to the nature of young children’s language and
cognitive development, the reliability of child diagnoses should be viewed with caution.

References


Donaldson Brown Hotel and Conference Center.


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221). Reprinted with permission. No further reproduction authorized without written permission of the ERIC
Clearinghouse on Counseling & Student Services.
Overview
The DSM-IV-TR (American Psychiatric Association, 2000) contains a myriad of disorders that are usually first diagnosed in infancy, childhood, or adolescence. Although the provision is made for this category, it is often difficult to make a clear distinction between adult and childhood disorders. When diagnosing children or adolescents, it is imperative that counselors not limit the diagnosis to a specific category. If the client meets the full criteria for a disorder, then a diagnosis should be considered. Because of the brevity of this paper, each disorder will not be extensively elaborated. However, the essential features of each disorder and a summarization will be presented. The following disorders are included in this section of the DSM-IV-TR:

Mental Retardation
Mental Retardation refers to substantial limitations in cognitive functioning. It is characterized by significantly subaverage general intellectual functioning, existing concurrently with related limitations in two or more of the following adaptive skills areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety. In addition, the onset of Mental Retardation must occur before age 18. Persons with Mental Retardation have typically been classified according to the degree of severity of their problems. Mild, moderate, severe, and profound retardation are used to specify the degree of severity. The following are the approximate IQ levels used to specify the severity of Mental Retardation: mild retardation, IQ level 50-55 to approximately 70; moderate retardation, IQ level 35-40 to 50-55; severe mental retardation, IQ level 20-25 to 35-40; and profound mental retardation, IQ level below 20-25.

Learning Disorders
Learning Disorders, formerly known as Academic Skills Disorders, are diagnosed when there is a discrepancy of more than 2 standard deviations between academic achievement and IQ. Usually, the client’s achievement on mathematics, reading, or written expression is below what is expected for age, schooling, and level of intelligence. Also, learning problems should adversely affect academic achievement or daily living that require reading, writing, or mathematic skills.

Motor Skills Disorder
Developmental Coordination Disorder is associated with significant impairment in the development of motor coordination. Children may display clumsiness when performing daily living tasks. For example, buttoning shirts, tying shoelaces, walking, or crawling. Diagnosis is made if developmental coordination is not a result of a medical condition, and significantly interferes with daily living activities and academic achievement. If Mental Retardation is present, developmental coordination must be in excess of what is usually associated with the degree of Mental Retardation.
Communication Disorders

The following communication disorders are included in the DSM-IV-TR: Expressive Language Disorder, which can occur in individuals who have a family history of Communication or Learning Disorders and is usually recognized by age 3. Expressive Learning Disorder is diagnosed when the scores obtained from standardized measures of expressive language development are below those obtained from standardized measures of both nonverbal intellectual capacity and receptive language development. Difficulties with expressive language interfere with academic, social communication, and occupational achievement.

If the person suffers from a Mixed Receptive/Expressive Language Disorder, the individual will have difficulty understanding words, sentences or specific types of words. The client will score low on the standardized measure of nonverbal capacity. Problems with expressive language significantly interfere with academic or occupational achievement, and with social communication.

Phonological Disorder, formerly Developmental Articulation Disorder, is a failure to use developmentally expected speech sounds that are appropriate for age and dialect. The difficulties in speech sound production may interfere with academic or occupational achievement or with social communication.

The onset of Stuttering, a fluency disorder, is usually between the ages of two and seven years. Stuttering entails a disturbance in the normal fluency and time patterning of speech that is inappropriate for the individual’s age. The disturbance in fluency interferes with academic or occupational achievement, or with social communication.

Pervasive Developmental Disorders

The characteristics of many developmental disorders are not entirely distinct. In young children, differentiating among these conditions is often difficult. All of the disorders in this category are characterized by severe and pervasive impairment in several areas of development: communication skills, interests and activities, the presence of stereotyped behavior, and reciprocal social interaction. The Pervasive Developmental Disorders are usually associated with a myriad of other medical conditions. Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, and Asperger’s Disorder are included in this category.

Attention-Deficit and Disruptive Behavior Disorders

Individuals with attention problems display persistent patterns of distractibility and or hyperactivity-impulsivity. The onset is usually before age seven. Impairment from the symptoms must be present in at least two settings. For example, the symptoms must be present at home and at school or work. The majority of individuals with Attention-Deficit Disorder have symptoms of both inattention and hyperactivity-impulsivity. However, there are some individuals in whom one or the other pattern is predominate. The following are the subtypes of Attention-Deficit/Hyperactive Disorder (AD/HD): AD/HD, combined type; ADHD, predominantly inattentive type; and ADHD, hyperactive-impulsive type.

Feeding and Eating Disorders of Infancy or Early Childhood may be due to a general medical condition. For example, an infant’s eating habits may change if he or she suffers from a gastrointestinal or endocrinological condition. However, a diagnosis of Feeding Disorder of Infancy or Early childhood should be made if there is a persistent failure to eat adequately with significant failure to gain weight or significant loss of weight over at least one month. Additionally, the onset of the disorder must be before age six.
**Tic Disorders**

A tic is characterized by rapid, recurrent vocalization or stereotyped motor movement. Tourette’s Disorder, Chronic Motor or Vocal Tic Disorder, and Transient Tic Disorder are three disorders included in this section. Tourette’s Disorder is characterized by recurrent motor or phonic tics that usually appear by age seven and have a waxing-and-waning course (Pauls, Leckerman, & Cohen, 1993). This disorder causes significant impairment in occupational, social, or related areas of functioning and the onset is before age 18. Chronic Motor or Vocal Tic Disorder is characterized by recurrent vocal or motor tics, but not both. Tic Disorder differs from Tourette’s Disorder in which there must be both multiple motor and one or more vocal tics. Like Tourette’s Disorder, the diagnosis should be made if the disturbance is not due to physiological effects of a substance or a general medical condition, there is significant distress in social or occupational functioning, and the onset is before age 18. The essential features of Transient Tic Disorder are the same as for Tourette’s Disorder, except that the tics are single or multiple motor and or vocal tics, may occur several times a day, and may occur daily for at least four weeks but for no longer than twelve consecutive months.

**Elimination Disorders**

Encopresis, repeated passage of feces into inappropriate places, and Enuresis, repeated voiding of urine on to bed or clothes are included in Elimination Disorders. These diagnoses should be made whether the behavior is intentional or involuntary, but when the disorder is not due to a general medical condition or the physiological effect of a substance. Also, Encopresis should be diagnosed if the person is at least four years old and the behavior occurs at least once a month for at least three months. However, the diagnosis of Enuresis should be made if the child is at least five years-old and behavior occurs twice per week for at least three months.

**Conclusion**

The DSM-IV-TR is a useful guide in diagnosing psychological disorders. However, the DSM-IV-TR should not be the sole criteria for diagnosis. The counselor’s clinical judgement as well as cultural and ethnic considerations are important in the diagnostic process. Proficiency in the DSM-IV-TR is critical for professional counselors, and its use will assist counselors with accountability and record keeping. Finally, an essential benefit of the DSM-IV-TR is the improvement of treatment planning, particularly with infants, young children, and adolescents.

**References**


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Attention Deficit/Hyperactivity Disorder (AD/HD)

Robert R. Erk

Counselors in schools, agencies or counseling centers, and private practice are increasingly viewed by many in our society as the contact person for information on the prevalence, probable causes, and treatment for individuals diagnosed with AD/HD. Research has given counselors useful information concerning AD/HD. Although estimates for the prevalence rate of AD/HD can vary, the disorder seems to occur in 5 to 10% of school-age children, adolescents, or adults. A few researchers have reported a prevalence rate as high as 20% of children who are school-age. AD/HD is diagnosed in boys three to five times more frequently than in girls.

There are sufficient lines of research evidence to support the claim that AD/HD is a genetically based disorder, resulting in an irregular metabolism of brain chemicals which are thought to fuel the AD/HD symptoms and problematic behaviors. These factors are presumed to significantly contribute to multiple problems with organization, attention, impulsivity, and hyperactivity at school and in the home. AD/HD is not a disease or illness, instead it needs to be viewed by counselors as a reflection of the physiology and biochemistry of the person. AD/HD should be regarded as a neurobiological or neurobehavioral condition that can be reliably diagnosed.

The DSM-IV-TR and AD/HD
Counselors should be skilled in the use of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) because it is the primary diagnostic tool for diagnosing AD/HD. The DSM-IV-TR (2000) codes AD/HD based on subtypes with different predominating symptom patterns that have persisted in the individual for at least six months. AD/HD is divided into three subtypes: AD/HD, Predominantly Inattentive Type which includes individuals who present six or more symptoms of inattention but not hyperactivity or impulsiveness; AD/HD, Predominantly Hyperactive-Impulsive Type which includes individuals with six or more symptoms of hyperactivity and impulsivity but who are not significantly inattentive; and AD/HD, Combined Type which includes individuals with six or more symptoms of inattention and six or more symptoms of hyperactivity-impulsivity. Subtypes of AD/HD help counselors recognize that a unique pattern of symptoms or problems exist and these individuals deserve special attention which focuses on the prominent features connected to their subtype.

The Diagnosis of AD/HD:
A Multimethod, Multisource, Multisetting Approach
The diagnosis of AD/HD can present particularly difficult diagnostic decisions. AD/HD is often mishandled with many individuals being undiagnosed or incorrectly diagnosed. When such occurs, these persons are denied the benefits of correct treatment. In cases of individuals suspected to have AD/HD, the designing of a multi-method (medical examination, direct observations, AD/HD behavior rating scales or checklists, psychoeducational evaluation, academic records or report cards, sociometric devices); multi-source (child, adolescent, or adult, parents, siblings, physician, school psychologist, school counselor, speech, hearing, or learning disabilities specialist, mental health, agency, or private practice counselor, peergroup); and a multi-setting (home or family, school or classroom, play activities, community) approach can produce the necessary collection of quality information or data. Importantly, this approach allows the counselor to verify that the diagnosis of AD/HD stands the test of time and assessment across methods, sources, and settings.
Multidimensional Treatment of AD/HD
Counselors are moving to the view that AD/HD is a condition that requires a longterm and broad-based treatment approach. Researchers have concluded that co-occurring or coexisting conditions such as academic underachievement, peer group or personal/social problems, learning disorders, communication disorders, oppositional defiant disorder, conduct disorders, anxiety disorders, attachment difficulties, mood swings, and depression may often be connected to individuals diagnosed with AD/HD. The weight of research evidence supports the multidimensional treatment approach as enhancing or optimizing the potential of individuals diagnosed with AD/HD and any comorbid or co-occurring conditions. Multidimensional treatment usually includes the following interventions: medication, individual or group counseling sessions, parent and teacher education and training on the disorder, behavioral management techniques, social skills training, self-esteem training, and family counseling. Counselors have become increasingly aware that the multi-skill deficits and multiple problems that these individuals can present necessitate an ongoing multiple treatment plan. Furthermore, treatment or interventions for AD/HD are more effective when they are tailored by counselors to accommodate the individual’s specific needs, address individual deficits, the antecedents and the consequences of the problematic behaviors, and embrace the interventions or resources needed to facilitate healthy development or growth.

Conclusions for Counseling Individuals with AD/HD
Counselors are encouraged to participate in the following ways: (a) serve as the coordinator or manager for the assessment and delivery of services or interventions for individuals diagnosed with AD/HD; (b) serve as a consultant for the problematic behaviors that are exhibited; (c) design or modify counseling programs or services to fit the needs of these individuals across settings (Counselors who hesitate to modify or adjust their therapeutic orientation or techniques to match the cognitive and behavioral deficits or problems of clients with AD/HD may experience far less success); (d) provide feedback on personal-social functioning or development; (e) organize and provide seminars or workshops on AD/HD for parents and teachers; and (f) serve as community advocates for individuals with the disorder.

An important component in the counseling of individuals with AD/HD can be the personal style of the counselor. The personal style of the counselor must be one of humane service, diplomacy, sensitivity, and compassion. It should be pointed out that moralizing, overly judgmental attitudes, and a condescending style assure poor rapport with AD/HD clients and their families and reduces or diminishes motivation for individuals with AD/HD and their families to invest in counseling.

Individuals with AD/HD view many of their problems as “not their own,” routinely blaming and distrusting teachers, parents, siblings, and peers. These individuals have often been traumatized by years of frustration, failure, and rejection. Many have used denial as their main defense mechanism and may have retreated into a make-believe world where their problems cannot hurt them. The counselor that can display accurate empathy, unconditional positive regard, genuineness, and maintain a here-and-now orientation in counseling may be able to develop a positive relationship with these clients.

Counselors should remember that in many instances counselees with AD/HD often are concrete in their thinking, operate largely on a here-and-now orientation; are often disinterested in delaying gratification or rewards, can be argumentative or inattentive; may not be especially verbal, have difficulty with internal speech and find verbalizing or articulation to be a tenuous task; and typically find that counseling lacks novelty or uniqueness after a session or two. Counselors who can build a positive relationship, identify areas of
achievement and good functioning, promote pride and pleasure, and salvage self-esteem may have the greatest chance to facilitate long-term change. Improving the self-esteem of these individuals should often be a core concern of counselors. Counselors who can thrive on the challenge that many individuals with AD/HD present and who can remain remarkably patient and understanding in counseling seem to have a distinct advantage.

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Delirium, Dementia, and Amnestic and Other Cognitive Disorders

Carol D. Verhulst

One of the unique abilities of the human brain is the capacity to experience a sense of self. Memory is a critical component of this sense of self because it is constructed from personal experiences that are catalogued in the memory. The loss of memory becomes one of life’s cruelest tragedies, robbing the person of a sense of self. When a person has ongoing problems with their memory and cognitive functions, the counseling professional’s clients are not the only affected person, families also suffer. An understanding of cognitive disorders, as classified by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association, 2000), will help the mental health counselor to correctly diagnose individuals affected by a loss of memory and cognitive functioning. Cognitive functions include memory, learning, and attention, and these functions control the acquiring, storing, and usage of information.

Delirium, Dementia, and Amnestic and other Cognitive Disorders comprise the second category of mental disorders in the DSM-IV-TR. Losses in cognitive functions or memory, or both, with the losses representing a significant change from previous levels of functioning characterize this category of disorders. The sections included in this category are delirium, dementia, amnestic disorders, and cognitive disorders not otherwise specified. The specified causes of each disorder are a general medical condition, the use of a substance (e.g., abusable substance or medication), or a combination of the two. While cognitive disorders are generally associated with older adults, some of these disorders can affect all ages, including children.

Delirium

Delirium is a disorder of attention. The term comes from the Latin de lira, meaning “off the path.” The primary feature is a disturbance of consciousness accompanied by a change in cognition. This disturbance develops over a short period of time, usually hours to days, and has a tendency to fluctuate during the day. The delirious person is less aware of the surrounding environment, becomes easily distracted, and has difficulty with concentrating and following commands. Changes in cognition can include memory impairment, disorientation, language disturbance, or a perceptual disturbance such as hallucinations, illusions, or misinterpretations (e.g., misinterpreting the sound of a door banging as a gunshot). Changes in the sleep-wake cycle are often associated with delirium, including nighttime sleeping difficulties, daytime sleepiness, or a complete reversal of the normal night-day sleep-wake cycle. This disorder is more prevalent in older adults, but also can occur in children and younger adults. Possible causes include a general medical condition, substance use, multiple medical conditions, or a combination of the two etiologies.

Examples of general medical conditions that may cause delirium include: fluid or electrolyte imbalances, systemic infections, metabolic disorders such as hypoglycemia, postoperative states, head trauma, and thiamine deficiency. Children and older adults are more susceptible to these medical conditions and to delirium caused by these conditions. The counselor may have difficulties in correctly diagnosing delirium, since it is considered relatively normal for both age groups to have difficulties in concentrating, to be easily distracted, and to seem disoriented. The counselor can interview family members to verify the sudden and unusual nature of the symptoms. Confirmation of the diagnosis of Delirium Due to a General Medical Condition requires evidence that the cognitive disturbance is the direct physiological consequence of a general medical problem.
The diagnosis must specify that medical condition as part of the diagnosis (e.g., Delirium Due to Thiamine Deficiency).

The symptoms for Substance-Induced Delirium are the same as for other deliriums, but the etiology must include a history of substance intoxication, substance withdrawal, exposure to toxin(s), or medication use that is etiologically related to the symptoms. The mental health counselor must name the specific substance as a part of the diagnosis. Delirium Due to Multiple Etiologies is indicated if the delirium has the following causes: multiple general medical conditions, a general medical condition plus substance or medication or toxin use, or a combination of any of these etiologies. The counselor actually codes each diagnosis separately; there is no coded diagnosis for Delirium Due to Multiple Etiologies. If the person displays the symptoms required for a diagnosis of delirium, but the etiology is different from the above etiologies, then the diagnosis is Delirium Not Otherwise Specified. An example of such an etiology is sensory deprivation.

**Dementia**

Dementia is a disorder that occurs almost exclusively in older adults and it is characterized by memory impairment and the development of multiple cognitive deficits. The term comes from the Latin de mens, meaning “from the mind.” Cognitive deficits include: aphasia (impaired language function), apraxia (impaired ability to perform motor activities despite intact motor abilities, sensory function, and understanding of the required task), agnosia (impaired ability to recognize or name objects despite intact sensory function), or a disturbance in executive functioning (e.g., performing new tasks). Memory and cognitive impairments must be severe enough to cause significant impairment in social or occupational functioning, and the impairments must represent a decline from a previous level of functioning. Other symptoms commonly found among dementia patients include: spatial disorientation, poor judgment and insight, disinhibited behavior such as neglecting personal hygiene or disregarding social rules of conduct, over-estimation of abilities, and personality changes.

The estimated prevalence rates for dementia are 5% of adults aged 65 and over, and 20% of adults aged 85 and over (Ineichen, 1987). The most common cause of dementia is Alzheimer’s disease, estimated to cause more than 50% of all dementias. The next most common cause is vascular disease. Other causes documented in the DSM-IV-TR are: HIV disease, head trauma, Parkinson’s disease, Huntington’s disease, Pick’s disease, Creutzfeldt-Jakob’s disease, other general medical conditions, substance-induced dementia, multiple etiologies, and causes not otherwise specified.

The onset of Dementia of the Alzheimer’s Type is insidious, usually beginning with slight deficits in short-term memory, and the course of the dementia is progressive and irreversible. Persons with dementia of the Alzheimer’s type gradually lose control over most cognitive functions. They may not be able to recognize family members, know how to eat or dress themselves, or remember where they are and how they came there. Patients with advanced dementia must be monitored 24 hours a day, since they may wander or attempt to perform activities that may become dangerous to themselves (e.g. leaving the stove on). Caretaking of the Alzheimer’s patient becomes a major strain on family members. Persons with dementia of the Alzheimer’s Type live, on average, from 8 to 10 years from the onset of the disease.

The diagnosis of this dementia is made only when other etiologies are ruled out, since the only definitive diagnosis can occur with a brain autopsy. The DSM-IV-TR distinguishes between early onset, defined as occurring before the age of 65, and late onset, defined as occurring after age 65. Subtypes identify prominent features of the patient’s dementia: with delirium, with delusions, with depressed mood, and uncomplicated type.
Persons with Vascular Dementia typically exhibit an abrupt onset that is followed by rapid changes in functioning, but the course also may be highly variable and could be gradual in nature. Exhibited memory and cognitive deficits are usually “patchy” in nature, since specific areas of the brain are being affected by the vascular disease process. As a result of this patchiness, certain cognitive functions may remain relatively unimpaired. For instance, the person may not remember the names of family members but remain capable of balancing the checkbook and taking care of personal hygiene activities. Early treatment of the underlying vascular problems may prevent further progression of this dementia. Subtypes of this dementia are the same subtypes used for Dementia of the Alzheimer’s Type: with delirium, with depressed mood, and uncomplicated.

The other causes of dementia occur much less frequently than Alzheimer’s and vascular disease. The following causes of dementia may occur before the age of 65: HIV disease, head trauma, Huntington’s disease, Pick’s disease, Creutzfeldt-Jakob’s disease, other general medical conditions, and Substance-Induced Persisting Dementia.

Of the above causes, Pick’s disease, Creutzfeldt-Jakob’s disease, and Substance-Induced Persisting Dementia have dementia as a prominent and expected outcome of that condition. Pick’s disease is a rare degenerative disease of the brain and Creutzfeldt-Jakob’s disease is a rare central nervous system disease. Huntington’s disease is an inherited degenerative disease involving cognition, emotion, and movement deficiencies, and rarely causes dementia.

Other causes of dementia more typically found in older adults are: Parkinson’s disease, which is a neurological condition, Dementia Due to Multiple Etiologies, and Dementia Not Otherwise Specified (NOS). Dementia NOS is the coding used for dementias that do not meet the criteria for any of the other dementias listed above.

Amnestic Disorders
Persons with amnestic disorders experience disturbances in memory that impair the ability to learn new information or recall previously learned information or past events. The memory disturbance is sufficiently severe to cause impairment in social or occupational functioning and represents a significant decline from previous levels of functioning. Unlike the television soap opera sufferer of amnesia, the person with an amnestic disorder has difficulty recalling new information as well as the recall of past events, and the person rarely forgets his or her own identity and sense of self. The person with an amnestic disorder usually lacks insight into the memory impairments and may deny having memory impairments despite evidence to the contrary. Amnestic disorders are classified as transient, with the duration lasting from hours to days and for no more than one month, or as chronic for disturbances lasting longer than one month. Causes of amnestic disorders are: general medical condition, substance use, including medications; and causes not otherwise specified, when the specific etiology is unknown. General medical conditions causing amnestic disorders are usually conditions that cause damage to the brain. Examples include head traumas, penetrating missile wounds, surgical intervention, and hypoxia. When evidence exists that the cause of the disorder is related to the persisting effects of substance use, the diagnosis is Substance-Induced Persisting Amnestic Disorder. Substance use includes drugs of abuse, medications, or toxins. This disturbance persists after the other effects of the substance use dissipate. Amnestic Disorder Not Otherwise Specified is the diagnosis for amnestic disorders with causes that do not match any of the above causes.

Cognitive Disorder Not Otherwise Specified
This category includes disorders caused by a general medical condition with cognitive dysfunctions that do not meet the criteria for any of the specific deliriums, dementias, or amnestic disorders previously listed in this
DSM-IV-TR category. Examples include: postconcussional disorder characterized by continuing cognitive impairments following a concussion caused by a closed head injury; and a mild neurocognitive disorder characterized by mild deficits in at least two areas of cognitive functioning; with each disorder not meeting the criteria for other cognitive disorders or for other mental disorders.

**Mental Health Counseling Implications**

The cognitive disorders belonging to this DSM-IV-TR category dramatically affect the social and occupational functioning of the person suffering from their effects. Such individuals may experience depression and anxiety, particularly during the early stages following diagnosis. These disorders dramatically affect family members, who also may experience depression and anxiety. Mental health counselors must be prepared to not only treat the direct effects of the disease, such as the loss of cognitive abilities and memory, but also the indirect effects arising from awareness of the increasing loss of the sense of self.

**References**


DSM-IV-TR and the Substance-Related Disorders

Guttorm Toverud

The fourth edition-revised of the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) was published in 2000. In DSM-I (1952) alcoholism and drug dependence were a subset of sociopathic personality disturbance. The DSM-II (1968) did not improve the diagnosis of chemically dependent persons, still considering them a threat to societal order.

In 1980, the DSM-III took a giant step away from implied moralizing and contained separate categories for substance use disorders including abuse and dependence. The DSM-III-R (1987) emphasized the alcohol dependence syndrome of Edwards and Gross (1976). This included compulsive use, characterized by cognitive, behavioral, and psychological factors. These less restrictive criteria allowed for the identification of the substance dependence symptoms of tolerance or withdrawal. The DSM-IV-TR Substance-Related Disorders encompass 13 different disorders: Alcohol-Related Disorders, Amphetamine (or Amphetamine-Like)-Related Disorders, Caffeine-Related Disorders, Cannabis-Related Disorders, Cocaine-Related Disorders, Hallucinogen-Related Disorders, Inhalant-Related Disorders; Nicotine-Related Disorders, Opioid-Related Disorders, Phencyclidine (or Phencyclidine-Like)-Related Disorders, Sedative, Hypnotic-, or Anxiolytic-Related Disorders; Polysubstance-Related Disorder; and Other (or Unknown) Substance-Related Disorders. These Substance-Related Disorders are divided into two groups; Substance Use Disorders (dependence and abuse) and the Substance-Induced Disorders which include: Substance Intoxication, Substance Withdrawal, Substance-Induced Delirium, Substance-Induced Persisting Dementia, Substance-Induced Persisting Amnestic Disorder, Substance-Induced Psychotic Disorder, Substance-Induced Mood Disorder; Substance-Induced Anxiety Disorder, Substance-Induced Sexual Dysfunction and Substance-Induced Sleep Disorder. The Substance-Induced Disorders are located in the sections of the DSM-IV-TR that have disorders of similar phenomenology. Adding Substance-Induced Disorders is a significant change from the DSM-III-R and aids in differential diagnosis. Comorbidity, or co-occurrence, plays an important role in the diagnosis and treatment of individuals with psychiatric disorders. Major Depression, Dysthymia, Anxiety Disorders (including phobia), Antisocial Personality Disorder and Sexual Disorders are the most conspicuous psychiatric disorders associated with the Substance-Related Disorders. Studies show that up to 50% of substance abusers have diagnosable psychiatric disorders (Miller, Leukefeld, & Jefferson, 1994). It may be difficult to make accurate diagnostic distinctions because symptoms can mimic each other. It is interesting to note that the seeking of treatment for substance abuse is associated with psychopathology. The literature is sparse and often not in agreement as to the relationship between substance use and psychopathology. This also is evident in terms of self-medication and the etiology of the different disorders, time of onset, clinical course, and what type of treatment is appropriate. Nathan (1991) argues that individuals need to be “clean and sober” for 4-6 weeks before one can reliably diagnose a psychiatric disorder that is not a Substance-Induced Disorder.

The DSM-IV-TR (2000) defines substance dependence as:

“... a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal, and compulsive drug-taking behavior. A diagnosis of Substance Dependence can be applied to every class of substances except caffeine” (p. 192).
Substance dependence entails a maladaptive pattern of substance use across all substance categories, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1) tolerance, as defined by either of the following:
   a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b) markedly diminished effect with continued use of the same amount of the substance;

2) withdrawal, as manifested by either of the following:
   a) the characteristic withdrawal syndrome for the substance
   b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;

3) the substance is often taken in larger amounts or over a longer period than was intended;

4) there is a persistent desire or unsuccessful efforts to cut down or control substance use;

5) a great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects

6) important social, occupational, or recreational activities are given up or reduced because of substance use;

7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (2000, p. 197).

Likewise, substance abuse is defined as: “a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances” (APA, 2000, p. 198). This definition is in contrast to the DSM-III-R where substance abuse became a residual category when the criteria for substance dependence was not met. Criteria for substance abuse entail a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home;

2) recurrent substance use in situations in which it is physically hazardous;

3) recurrent substance-related legal problems;

4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. The symptoms must not have ever met the criteria for Substance Dependence for the specific substance (APA, 2000, p. 199). It is now believed that the distinction between substance abuse and substance dependence is central to the diagnosis of the Substance-Related Disorders. In the DSMIV-TR, substance abuse is no longer a residual category. Substance abuse can now be diagnosed according to specific behaviors associated with the social consequences of substance use.

Substance dependence maintains the emphasis on compulsive use and social and occupational impairment from both the DSM-III and DSM-III-R. Recent studies have been conducted to respond to criticism from previous editions of the DSM regarding generalization of the dependence syndromes across substances. Morgenstern, Langenbucher, and Labouvie (1994) found that there was strong support for the employment of a single set of criteria for alcohol, cannabis, cocaine, stimulants, sedatives, and opiates. They did not find the same results for hallucinogens regarding dependence as hallucinogens do not appear to result in tolerance or withdrawal.
Langenbucher, Morgenstern, and Miller (1995) found that most drugs correlated with the test variables in the nosological comparison between DSM-III, DSM-IV-TR, and the ICD-10. Even lifetime DSM-IV diagnosis of alcohol, cannabis, cocaine and opiate dependence was deemed excellent in terms of reliability.

In conclusion, the DSM-IV-TR is the latest in a series of The Diagnostic and Statistical Manual of Mental Disorders attempting to unify the nomenclature. The Substance-Related Disorders section enables a clinician to diagnose substance dependence without evidence of tolerance or withdrawal. This strengthens the validity of the criteria across all substance classes.

References


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Dual Diagnosis and Co-Dependency

J. Scott Hinkle

Dual diagnosis, a common problem, is the combination of a DSM-IV-TR (APA, 2000) Axis I disorder and a Substance-Related disorder (Jonas & Gold, 1992). The percentage of individuals in treatment for drug and alcohol difficulties, who also have at least one mental disorder, ranges from 30% to 70%. A significant number of the nearly one million people with chronic mental disorders in the United States have problems with substance dependence. Of the approximate three million homeless people in this country, it is estimated that somewhere between 33% and 75% have this comorbidity (Wilens, O’Keefe, O’Connell, Springer, & Renner, 1993). For example, over half of cocaine abusers have a mood disorder (Sederer, 1990). Similarly, the prevalence of depression in the alcohol dependent population has been estimated to range from 20% to 90%. A lifetime history of substance-related problems was found in 47% of individuals with schizophrenia, 56% of those with bipolar disorder, and 86% of these with antisocial personality disorder (Reiger, Narrow, & Rae, 1990). Unfortunately, dual diagnosis is often related to crime, domestic violence, suicide, fatal accidents, job loss, family dysfunction, and poor treatment outcome (Goodwin & Lotterhos, 1991; McKelvy, Kane, & Kellign, 1987; Wilens et al., 1993).

Dixon, Haas, Weiden, Sweeney, & Francis (1990), among others, have argued that substance-dependent individuals use substances to self-medicate distressful affective states and other psychological symptoms. Allen and Frances (1986) have described four possibilities that may contribute to the co-occurrence of a substance-related disorder with another mental disorder. First, the co-existing mental disorder could be a direct result of the pharmacologic and behavioral consequences of the substance abuse. This position also has been posited by Schuckit (1983, 1988) for mental disorders that begin during or after the onset of a substance-related disorder. Secondly, the substance-related disorder may be the direct result of another preexisting mental disorder, such as depression or panic disorder, which can lead to self-medication. Thirdly, the presence of a substance-related disorder in the presence of a mental disorder could simply be coincidental. This option, however, is becoming unacceptable since studies are revealing that the risk of almost all of the mental disorders is elevated among individuals with any history of substance or alcohol abuse. Lastly, both the substance-related and the co-occurring mental disorder could be the result of a third, unidentified, common etiological factor that may be biological, familial, or social in nature.

Making the Dual Diagnosis

Dual or multiple diagnoses are easy for professionals to overlook. The term “dual diagnosis” is not restricted to psychoses and mood disorders alone, but includes anxiety disorders, eating disorders, and other disorders that interfere with full well-being (Zweben, 1992). Dual diagnoses can result in diagnostic confusion since they may have a different course and prognosis because of the interaction between the disorders (Sederer, 1990).

Substance abuse affects all aspects of life. For instance, employment difficulties include absenteeism, poor work performance, stressed work relationships, being out of step with peers, and secondary difficulties associated with the rigors of the workplace (Fahnestock, 1993). Thus, data from all life areas needs to be obtained in order to make an accurate dual diagnosis.
There exists a need for specific diagnostic criteria for identifying clients with diagnoses encompassing mental and substance abuse disorders. Furthermore, dual diagnoses clients are not a homogeneous group. For example, what may work for chronically depressed alcohol-dependent individuals may not work for anxious individuals who abuse prescription drugs (see Ford, Hillary, Giesler, Lassen, & Thomas, 1989).

**Treatment of Dual Diagnosis**

The presence of a dual diagnosis influences the timetable of recovery and plays an underestimated role in relapse (Zweben, 1992). For instance, substance abuse clients with a co-existing personality disorder have a poorer response to intensive treatment (Nace & Davis, 1993). Furthermore, many alcohol-dependent individuals will not require medication (e.g., an antidepressant) once they are sober. However, a subgroup of clients who continue to be depressed when sober may have a co-existing major depressive disorder which requires intensive treatment (Sederer, 1990).

Individuals with a dual diagnosis have historically been difficult to counsel. They frequently use emergency services, are often misdiagnosed, and are at risk for violence and suicide. Specialized services are needed for this group because of their poor fit in either the mental health or substance abuse treatment systems. Individuals with a dual diagnosis are often treated by mental health counselors who have little formal training or experience with substance abuse, or such patients are seen in the substance abuse arena by individuals with little training in mental health counseling. Many detoxification facilities cannot accept clients who require psychotropic medications, while many psychiatric units are hesitant to admit a patient prior to detoxification (Wilens et al., 1993). When these individuals are seen jointly, it is likely that information is not shared. Moreover, dual diagnosis clients may not be eligible for services because their mental disorder is not clearly evident. Therefore, counselors should be cross-trained in comorbid substance abuse and mental disorder diagnosis and treatment (Wolfe & Sorensen, 1989). Dually diagnosed clients typically are not good candidates for medication therapy and are often shuttled back and forth between psychiatric hospitals and alcohol abuse programs. In either event, therapists typically treat one disorder rather than integrate treatment strategies (Rahav et al., 1993). Moreover, dual diagnosis subgroups may require different treatment plans. For instance, higher functioning individuals may be referred to Alcoholics Anonymous and counseling. Moderate functioning individuals with family and social support may receive similar treatment, but may require more intensive counseling or inpatient treatment. Low functioning individuals may require professionally staffed medical treatment and long-term follow-up care (Morris & Wise, 1992). Interestingly, McLellan (1986) has found that individuals with substance dependency and a mental disorder, who are counseled by peers (i.e., “recovering counselors”), decreased in functioning and had lower follow-up recovery rates than those treated by professionals. In addition, there appears to be a significant positive relationship between degree of progress and duration of treatment. Highly structured environments that incorporate small and large counseling groups have been found to be effective in the treatment of dual diagnosis. This includes aspects of psychoeducational recovery-directed self-help groups that focus on self-awareness (Wilens et al., 1993). In addition, family and relationship counseling is often beneficial, particularly when co-dependency is an issue.

**Co-Dependency**

There is currently a plethora of information on the concept of co-dependency. However, it is not recognized in the DSM-IV-TR. Harper (1988) has noted that billions of dollars in health insurance is spent on alcoholism treatment and that many professionals in the chemical dependency field would like to fit co-dependency into a diagnostic and health insurance reimbursable category. Greenleaf (1981) used the term co-alcoholic to describe an adult who “assists in maintaining the social and economic equilibrium of the alcoholic person” (p. 3). The
term co-alcoholic was transformed to co-dependency in order to be a more inclusive term for people involved in a relationship with a substance dependent individual (Cermak, 1986). The concept of co-dependency has its roots in the theory of alcoholism as a family issue (see Shorkey & Rosen, 1993; Woititz, 1983). Subby and Freil (1984) have defined co-dependency as a “dysfunctional pattern of living and problem solving which is nurtured by a set of rules within the family system...these rules make healthy growth and change very difficult” (p. 3).

Co-dependency has been further defined as the product of dysfunctional families in which children cannot develop a clear identity. Yet, another perspective focuses on real or perceived abuse and neglect as the cause of co-dependency (Subby, & Friel, 1984). Moreover, without empirical documentation, co-dependency has been expanded to include enabling relationships with disturbed individuals who are not necessarily substance dependent (Shorkey & Rosen, 1993).

Co-dependent individuals often share in the denial of the problem with the addicted person. They believe the problem will magically discontinue, that life circumstances will mitigate against the problem, or that the dependent person will suddenly recognize the problem and change his or her behavior (Whitfield, 1984). The non-abusing codependent person may lose his or her sense of identity over time and may habitually focus on protecting and meeting the needs of others. They also may be unprepared for the major changes in their social and emotional environment and may experience devastating fear, anxiety, resentment, and depression as the familiar is replaced by the unknown and unpredictable (Shorkey & Rosen, 1993). Co-dependency can be described within a family of origin framework in which people reared in dysfunctional families fail to develop a clear and coherent sense of personal identity (Shorkey & Rosen, 1993). A family systems, problem-solving framework is useful not only for conceptualizing how co-dependency develops, but also is helpful as a guide to assessment and treatment with families having a chemically dependent member (D’Zurilla & Goldfried, 1971; Nezu & D’Zurilla, 1981a, 1981b).

When problem-solving efforts fail, the co-dependent individual may suffer heightened emotional disturbances as a result of repeated frustrations. This process often continues until one or more family members develops an emotional disorder that requires treatment, the family system deteriorates, someone dies, or the chemically dependent family member begins to take steps toward recovery (Woititz, 1983). Shorkey and Rosen (1993) have asked: Why do so many individuals choose ineffective problem-solving strategies to attain personal or family goals? The answer may be a lack of knowledge about the dynamics of an addicted family system. Fortunately, knowledgeable mental health counselors can be of great service to such families.

References


As with most other substances of abuse, Cannabis-Related Disorders should be assessed in the light of the diagnostic guidelines for all Substance-Related Disorders. The generic diagnosis criteria apply to Cannabis Dependence, Cannabis Abuse, and Cannabis Intoxication, however, additional information specific to cannabis, is worth noting. The percentage of delta-9-tetrahydrocannabinol (THC), the compound responsible for the psychoactive effects of cannabis, has considerably increased in the past three decades, although its content in marijuana tends to vary. This needs to be taken into account in diagnosing and in attempting to evaluate possible physiological effects. Other Cannabis-Induced Disorders (not discussed in this paper) which are included in the Diagnostic and Statistical Manual of Mental Disorders, Fourth EditionRevised (2000) are: Cannabis Intoxication Delirium, included in the Delirium, Dementia, and Amnestic and other Cognitive Disorders; Cannabis Induced Psychotic Disorders, found in the Schizophrenia and Other Psychotic Disorders section, and Cannabis-Induced Anxiety Disorder, discussed under Anxiety Disorders. The rationale for this separate grouping lies in their shared phenomenology with each specific cluster of disorders. However, these diagnoses are actually made under the Substance-Related Disorders category.

**Cannabis Dependence**
The Cannabis Dependence diagnosis is given to individuals who display compulsive use and who have developed tolerance due to chronic use. Individuals with this diagnosis spend a great deal of their time obtaining the drug, and use high doses of it throughout the day, for months or years (APA, 2000).

As stated in the DSM-IV-TR, physiological dependence is not generally present, and psychological dependence, while not common, is more likely to occur. Some studies, however, have shown that physical dependence can take place if the drug is administered in very high doses at short intervals, leading to some short duration withdrawal symptoms such as sweating, nausea, diarrhea, and mood changes. Jones (1992) points out that the reason why tolerance and dependence may not be prevalent is that “...most controlled research studies..... give experimental doses only during waking hours, thus allowing significant intoxication-free periods each day” (p.112). When doses are comparable to those needed for opiates or alcohol intoxication, abstinence symptoms become apparent.

**Cannabis Abuse**
Cannabis Abuse is associated with interference with work or school performance as well as legal and family problems, provided that tolerance stays at moderate levels and that these problems are not the result of compulsive use. The latter would warrant a dependence diagnosis.

Because cannabis has been a very popular drug for years among adolescents, it is useful to recognize the experimental nature without further consequences of its use, among young individuals. Keeping this perspective in mind will aid the clinician in avoiding a premature diagnosis. Conversely, frequent monitoring of these types of users is advisable in order to ascertain the risk of later multiple drug use (Millman & Beeder, 1994).

**Cannabis Intoxication**
Individuals would be considered intoxicated by cannabis if, shortly after recent use of the drug, they were to display significant maladaptive behaviors and psychological changes, along with two additional signs such as
dry mouth, tachycardia, increased appetite, and/or conjunctival injection. It is important for the clinician to note that these symptoms occur when it is clear that other physical or mental disorders which could account for the cause, are not part of the diagnosis.

**Inconclusive Findings**
There seems to be some contradiction surrounding the existence of withdrawal symptoms, as well as in the long term physiological and psychological effects of cannabis use. The DSM has not included a section on withdrawal symptoms for Cannabis Related Disorders, due to the lack of clinical significance associated with research findings.

The incidence of cannabis in the development of schizophrenia and other psychoses remains to be proven, in spite of some study results pointing in that direction. Other long term effects, such as organic brain damage are mentioned in the literature, although not everyone espouses that concept.

A motivational syndrome as a result of heavy cannabis use, has been described as an overall absence of motivation and goal directed activity, as well as lack of ambition and a deterioration of self-caring habits and social skills. Studies conducted in relation to this syndrome, however, have been flawed due to the absence of control groups or other factors compromising their validity, thus limiting its diagnostic feasibility (Millman & Beeder, 1994).

**Treatment**
Due in part to its popularity during the 1960s, and to the significance of this date among adolescents and young adults, individuals do not tend to seek treatment or acknowledge heavy use, as they do with other substances. According to the DSM-IV-TR, knowledge of physical or psychological consequences may not deter cannabis dependent individuals from continuous use. Contrary to this criteria, Erickson’s (1989) study found that “a concern with health effects might restrain (though clearly not eliminate) the frequency of use in a group of committed users” (p. 181). This would suggest that psychoeducational programs would be a beneficial treatment. But it is important to keep in mind that effective treatment needs to be encompassing and should address the needs of a population that may have complex lifestyles (e.g., multiple drug use). The inclusion of alternative rewards, as well as a focus on what should be done instead of focusing only on what should not be done, is critical during treatment (Millman & Beeder, 1994) Some of the modalities used in the treatment of cannabis abuse, resemble that of other substance disorders. Group counseling has proven to be beneficial in most cases, whereas 12-Step programs have not been highly regarded among cannabis users, mainly due to a reported lack of commonality. Other treatment modalities may include: family counseling, psychotherapy, behavioral therapy, and inpatient programs.

Cannabis-Related Disorders have been studied for a number of years, however, the presence of contradictory findings concerning numerous diagnostic and treatment issues warrants further intensive research.

**References**


Schizophrenia and Other Psychotic Disorders
Wendy B. Charkow

Many definitions of the term psychotic currently exist. Generally, they relate to three separate characteristics: the presence of active symptomology such as delusions and/or hallucinations; impairment of functioning so that the individual is unable to meet ordinary life demands; and the loss of ego boundaries or reality testing. Psychotic Disorders share a common set of symptomology, and are categorized as disorders of thought, speech, affect, orientation, and psychomotor activity. For example, many individuals suffering from a Psychotic Disorder may experience grammatical incoherence, inappropriate affect, and thought broadcasting (the individual believes that everyone can hear his or her thoughts). In addition, Psychotic Disorders are associated with delusional activity, such as delusions of persecution or of grandeur, and may feature hallucinations or perceptions that are not reality-based.

Psychotic Disorders may be the result of an abnormality in the brain, defective genes, chemical imbalances, or an unsupportive family environment. Some assert that Psychotic Disorders result from living in an uncaring society that too strongly emphasizes the importance of conformity among all members. It is most probable that Psychotic Disorders result from a myriad of factors. Whatever the etiology, it is generally accepted that those afflicted suffer greatly and can benefit from a combination of psychotropic treatments, “talking” therapy, and the support of significant others.

Schizophrenia
Schizophrenia is the most commonly given diagnosis for individuals with Psychotic Disorders. The lifetime prevalence of Schizophrenia is usually found to be between 0.5% and 1%, with incidence rates at approximately 1 per 10,000 persons per year. An individual with Schizophrenia can best be described as one who engages in bizarre ways of thinking, behaving, and feeling that interfere with his or her ability to function in everyday life. Whitaker and Puente (1992) described the three primary characteristics of Schizophrenia as lack of communication with others, inability to distinguish fantasy from reality, and extreme fear. Schizophrenic symptoms are often categorized as either positive or negative. Positive symptoms are usually acute, and include phenomena such as delusions or hallucinations. Negative symptoms tend to present themselves as chronic and include social isolation, ashenonia, and blunted affect. In order for an individual to be accurately diagnosed with Schizophrenia, the characteristic signs and symptoms must have been present for a significant amount of time in a one-month period, with signs of Schizophrenia persisting for at least six months (APA, 2000).

Five subtypes of Schizophrenia have been established by the DSM-IV-TR. The “Paranoid Type” is specified if the prominent symptoms include a preoccupation with frequent delusions or hallucinations. A second subtype, “Disorganized Type” is specified when the individual displays prominent disorganization of speech, behavior, and affect. “Catatonic Type” is indicated when the person experiences two or more of the following: motor immobility, excessive motor activity, extreme negativism, mutism, peculiarities of voluntary movement, echolalia, and echopraxia. The fourth subtype, “Undifferentiated Type” is accurately applied when the person displays characteristic symptoms of Schizophrenia but cannot be classified as under the first three subtypes. Finally, the fifth subtype, “Residual Type” is used when there has been at least one episode of Schizophrenia, but the individual no longer displays positive psychotic symptoms. There is still evidence in this subtype of negative symptoms or less severe positive symptoms. This subtype may represent a transition between active episodes and remission, or may be present for years.
The average age of onset of Schizophrenia is between the mid to late twenties. According to McGlashan (1994), approximately 10% of cases occur after the age of 40. The majority of individuals display gradual characteristics of this disorder before active phase symptoms appear. The course and outcome of this disorder vary widely among individuals: some display exacerbations and remissions, whereas others display chronic symptoms indefinitely. Complete remission is rare, and interventions are generally aimed at helping the individual develop coping skills and improving his or her quality of life.

**Schizophreniform Disorder**

Unlike persons with Schizophrenia who display symptoms for at least 6 months, individuals with Schizophreniform Disorder display symptoms of Schizophrenia from one to six months. In addition, individuals diagnosed with Schizophreniform Disorder do not necessarily experience impaired social or occupational functioning as do those with Schizophrenia (APA, 1994).

The DSM-IV-TR established two specifiers for Schizophreniform Disorder. The first specifier, “With Good Prognostic Features” is applied when at least two of the following characteristics are evident: the individual displayed symptoms within four weeks after the first noticeable change in behavior, experienced confusion or perplexity at the apex of the psychotic episode, displayed good premorbid functioning, or experienced no blunted or flat effect. If these features are not evident, “Without Good Prognostic Features” is then applied. Generally, one-third of those diagnosed with Schizophreniform Disorder recover within six months, whereas the following two-thirds progress to a diagnosis of Schizophrenia or Schizoaffective Disorder.

**Schizoaffective Disorder**

The major characteristics of Schizoaffective Disorder entail concurrent symptoms of both Schizophrenia and either a Depressive, Manic, or mixed Episode for a substantial duration of the Psychotic Disorder. In addition, delusions or hallucinations must be present for at least a two-week period with no signs of mood disturbance. The average individual with Schizoaffective Disorder first experiences delusions and hallucinations for a two-month period, followed by a major depressive episode. These conditions normally occur together for about three months, after which the individual recovers from the major depressive episode. The psychotic symptoms usually persist for about one month before disappearing (1994).

The DSM-IV-TR established two subtypes for this disorder. The first subtype, “Bipolar Type” is specified when the mood disturbance is either a Manic or mixed Episode. The second subtype, “Depressive Type” is specified if the mood disturbance includes only a Major Depressive Episode (APA, 2000).

The typical age of onset is early adulthood, although it can occur anytime between adolescence and later life. The prognosis for this disorder is generally more positive than that for Schizophrenia, although it is worse than the outcome for Mood Disorders. It is possible that those diagnosed as “Bipolar Type” can expect a better prognosis.

**Delusional Disorder**

Individuals with Delusional Disorder experience bizarre delusions (beliefs not based in reality), but none of the symptoms that characterize the other psychotic disorders. If the individual’s functioning is impaired, it is due to the impact of the delusions. These delusions must last for at least one month.

The DSM-IV-TR has established seven subtypes of Delusional Disorder. The first subtype, “Erotomanic Type” involves delusions that another person is in love with the individual. The second subtype “Grandiose Type” is noted when the individual experiences delusions of inflated power, worth, knowledge, or special relationships. “Jealous Type” is specified if the individual has delusions that his or her sexual partner is unfaithful. The fourth subtype “Persecutory Type” involves delusions that the individual is being treated in a malevolent manner.
“Somatic Type” is specified when the delusions involve a physical defect or medical condition. The sixth subtype “Mixed Type” is noted when there are delusions that are characteristic of more than one of the type mentioned above. Finally, “Unspecified Type” is used when the dominant delusional belief cannot be classified into the suggested typology.

Unlike Schizophrenia, the average age of onset for Delusional Disorder is generally in middle to late adulthood. The course is quite variable, with some individuals experiencing intermittent delusions with periods of remission, some experiencing chronic delusions, and some experiencing a full remission.

**Brief Psychotic Disorder**

The main characteristic of Brief Psychotic Disorder is a sudden onset of psychotic symptoms, including delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior. The duration of these symptoms is one day to one month, with eventual full return to premorbid functioning. The DSM-IV-TR has established specifiers for this diagnosis dealing with the presence of marked stressors or a postpartum state prior to the psychotic episode (APA, 2000).

This disorder is uncommon. The average age of onset is in the late twenties or early thirties. It should be noted that if the symptoms last longer than a month, a diagnosis of Schizotypal Disorder can then be applied.

**Shared Psychotic Disorder**

Shared Psychotic Disorder occurs when an individual who is closely involved with someone who already has a Psychotic Disorder with prominent delusions, also experiences the same or similar delusions. This most often occurs in close two-person relationships, where the person who is diagnosed with Shared Psychotic Disorder was initially healthy. This is a rare disorder that has not been widely researched. When intervention occurs and the individual is separated from the person with the primary Psychotic Disorder, the delusions disappear.

**Psychotic Disorder Due to a General Medical Condition**

An individual diagnosed with Psychotic Disorder due to a General Medical Condition experiences prominent delusions or hallucinations that are a direct physiological consequence of a medical condition. The delusions or hallucinations cannot be accounted for by another mental disorder, or they occur solely in the course of a delirium. Medical conditions that may cause psychotic symptoms include neurological conditions, endocrine conditions, metabolic conditions, fluid or electrolyte imbalances, hepatic or renal diseases, and autoimmune disorders associated with the central nervous system. The onset and course of this disorder reflect the etiological medical condition (APA, 2000).

**Substance-Induced Psychotic Disorder**

An individual who receives the diagnosis of Substance-Induced Psychotic Disorder can best be described as experiencing delusions or hallucinations that develop during Substance Intoxication or Withdrawal, or are related to medication use. The clinician must show that the disturbance is not better accounted for by a Psychotic Disorder that is not substance induced; therefore, symptoms must not precede substance use or persist for a significant amount of time following the cessation of substance use. Further, the psychotic symptoms must not occur exclusively during a delirium. When coding this disorder, the subtypes, “With Delusions” or “With Hallucinations” and the specifiers, “With Onset During Intoxication” and “With Onset During Withdrawal” should be applied to the diagnosis, as well as the specific substance that induces the disorder (APA, 2000).
Associated Disorders
Research has shown that Psychotic Disorders are often associated with other psychological problems such as various Substance-Related Disorders, Mood Disorders, Personality Disorders, Obsessive Compulsive Disorder, Dementia of the Alzheimer’s Type, Vascular Dementia, and Body Dysmorphic Disorder. The DSM-IV notes that Schizophrenia shares characteristics with and may be preceded by Schizotypal, Schizoid, or Paranoid Personality Disorder. The DSM-IV also points out that many individuals with psychotic disorders also experience mood disturbances. It is important for clinicians to take these secondary problems into account and incorporate them into the evaluation and treatment of clients (APA, 2000).

Atypical Psychotic Disorders
It is often a difficult task to apply a DSM-IV diagnosis when evaluating persons with psychotic disorders; many of the symptoms for the different disorders are associated. In addition, it is sometimes confusing when a mood disorder or personality disorder is superimposed on a psychotic disorder. Finally, not all of the clients with presenting psychotic symptoms can be easily classified into specific disorders. Therefore, the DSM-IV-TR contains a Not Otherwise Specified (NOS) category in each diagnostic class to be used when the clinical features of a disorder suggest the class of disorders but do not meet all of the criteria for any of the specific disorders in that class (APA, 2000). Psychotic Disorder NOS may include, but is not limited to, the following examples: (1) postpartum psychosis that does not meet the specific criteria for any of the specific Psychotic Disorders or Mood Disorders with Psychotic Features; (2) psychotic symptoms that have lasted for less than one month without remission; (3) persistent auditory hallucinations without any other features; (4) persistent non-bizarre delusions with periods of overlapping mood episodes that are present for a substantial portion of the delusional disturbance; and (5) situations when psychotic symptoms are present but cannot be determined if caused by the psychotic disorder, medical condition, or substance use (APA, 2000).

Continuum of Prognosis
Research shows that complete recovery for individuals with psychotic disorder is rare, although there may be long periods of remission. Therefore, individuals presenting with psychotic disorders generally require long-term services and interventions. Clients will benefit from a constellation of different treatments including neuroleptic medication, vocational rehabilitation, and counseling. In addition, many individuals with psychotic disorders require assistance both in coordinating interventions and in functioning in everyday life. Therefore, it is important for counselors to act as supportive advocates and coordinators for these clients.

References


Overview
Of the mental disorders described in the DSM-IV-TR (American Psychiatric Association [APA], 2000), the Mood Disorders are perhaps the most commonly found in the general public. Mental health counselors in many different settings are likely to work with individuals presenting with a mood disorder. In addition, symptoms mimicking those of the mood disorders are likely to be associated with other presenting problems. For these reasons, it is important for counselors to have a good working knowledge of the mood disorders described in the DSM-IV-TR. Familiarity with the disorders will assist mental health counselors in reaching accurate diagnostic impressions and in setting meaningful treatment goals for clients. Subsequent treatment strategies are then more likely to contribute to a successful and timely resolution of client distress.

An Overview of the Mood Disorders in DSM-IV-TR
The DSM-IV-TR divides the mood disorders into three broad categories, the Depressive Disorders, Bipolar Disorders, and Other Mood Disorders. Within each category, specific disorders are described in terms of their diagnostic features; specifiers related to the characteristic patterns of symptoms normally found in the disorder; associated features; and specific culture, age, and gender features. Further information related to prevalence in the population, typical course or progression of symptomatology, and characteristic familial patterns is presented. In addition, considerable discussion of differential diagnosis is provided for each disorder. Finally, very specific diagnostic criteria are presented for each of the specific mood disorders.

The information on the specific disorders is preceded by an extensive discussion of mood episodes. These episodes are described in a similar fashion to the disorders, but do not themselves receive categorization as separate diagnoses. Rather, they are presented as the building blocks of the disorders which follow. The mood disorders section in the DSM-IV-TR concludes with a section presenting specifiers intended for use with these episodes. This information is presented in two subsections. The first discusses specifiers intended for use in describing the most recent episode. The second presents specifiers describing the course of recurrent episodes.

Mood Episodes
The mood episodes are closely related to the disorders themselves. Four distinct episodes are identified. These are major depressive episode, manic episode, mixed episode, and hypomanic episode.

A major depressive episode is presented as “a period of at least 2 weeks during which there is either depressed mood or the loss of interest or pleasure in nearly all activities” (APA, 2000, p. 349). A list of seven additional specific symptoms includes disturbance in eating patterns or weight, disturbance in patterns of sleep, observable changes in psychomotor behaviors, fatigue or energy loss, feelings of worthlessness or guilt not founded in reality, disturbance in thought or concentration, and recurrent thoughts of death or suicide. At least four of the seven symptoms, in addition to one of those noted above, must be present. As with all the mood disorders, symptoms must be associated with impairment in social, occupational, or other important areas of functioning, must not be due to a medical condition or the effect of a drug or medication. Also, the symptoms must not be better accounted for by a mixed episode or by the condition of bereavement.

A manic episode is presented as “a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood” (APA, 2000, p. 357). Abnormal mood must last for at least one week or require hospitalization prior to that time frame and must include at least three further symptoms taken from a list including inflated self-esteem, diminished need for sleep, pressured speech, racing thoughts, distractibility,
increased activity directed towards some goal, or excessive pursuit of pleasurable activities potentially leading to undesirable consequences. The symptoms must not be better accounted for by a mixed episode.

A mixed episode is described as a period of time in which the criteria both for a Manic Episode and for a Major Depressive Episode are met nearly every day (APA, 2000). The episode must last at least one week and be characterized by moods that alternate rapidly. Symptoms are again expected to interfere with social or occupational functioning or, in this case, to require hospitalization or be accompanied by psychotic features. A hypomanic episode is described as “a distinct period during which there is an abnormally and persistently elevated, expansive, or irritable mood” (APA, 2000, p. 365). At least three of the additional symptoms described for a manic episode must be present and there must be an unarguable change, noticeable to others, in normal functioning of the individual. Unlike the other episodes, however, impairment in social or occupational functioning need not be present.

**Depressive Disorders**

Perhaps the most commonly recognized mood disorder is Major Depressive Disorder. The primary identifying feature of a Major Depressive Disorder is the presence of one or more Major Depressive Episodes and the absence of a history of any Manic, Mixed, or Hypomanic Episodes. Additionally, the episodes in question must not be better accounted for by another mental disorder. Specifiers that may be applied to the current episode of a Major Depressive Disorder include mild, moderate, severe with or without psychotic features, in partial or full remission, chronic, with catatonic, melancholic, or atypical features, and with postpartum onset. Specifiers that may be applied to the course of the disorder include with or without full interepisode recovery and with seasonal pattern. Further, a diagnostic distinction is made between a Major Depressive Disorder, Single Episode and a Major Depressive Disorder, Recurrent, where two or more major depressive episodes distinguish the recurrent diagnosis. Dysthymic Disorder features “a chronically depressed mood that occurs most of the day more days than not for at least two years” (APA, 2000, p. 376). In addition, at least two of the remaining symptoms characterizing a major depressive episode must be present, except that thoughts of death or suicide, disturbance in psychomotor behaviors, and loss of interest or pleasure are not included in the list of relevant symptoms for Dysthymic Disorder. Specifiers applying to Dysthymic Disorder include early onset, late onset, or with atypical features. Finally, Depressive Disorder Not Otherwise Specified is the diagnosis used for a disorder with clinical symptoms of depression that do not meet the criteria for other depressive disorders, nor are they better accounted for by other mental disorders.

**Bipolar Disorders**

Bipolar I Disorder features a course including one or more manic episodes or mixed episodes. It is often, though not necessarily, characterized as well by one or more major depressive episodes. Bipolar I Disorder may be distinguished as Bipolar I Disorder, Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, or Most Recent Episode Unspecified. Further, the specifiers noted for Major Depressive Disorder, as well as With Seasonal Pattern and With Rapid Cycling, also may be applied to either the current or most recent episode. Symptoms and/or episodes should not be attributable to another mental disorder.

Bipolar II Disorder features a course including one or more major depressive episodes accompanied by at least one hypomanic episode. In addition, the symptoms may result in distress or impairment of social or occupational functioning and must not be attributed to another mental disorder. The disorder may be further distinguished as Bipolar II Disorder, Hypomanic or Depressed, as appropriate to the current or most recent episode. The specifiers noted for other Mood Disorders should also be included in the diagnosis, as appropriate.
Cyclothymic Disorder is characterized by a chronic, fluctuating mood disturbance involving numerous periods of hypomanic symptoms and numerous periods of depressive symptoms. Symptoms are not of the severity or duration to meet the criteria for a Manic Episode or a Major Depressive Episode, but they must not disappear for longer than two months in a two year period for an adult and must cause significant impairment in social or occupational function. Bipolar Disorder Not Otherwise Specified is the diagnosis reserved for disorders characterized by symptoms found in the bipolar disorders but not meeting the strict criteria for a specific disorder.

Other Mood Disorders
Mood Disorder Due to a General Medical Condition is the diagnosis set out for those disorders which feature “prominent and persistent disturbance in mood that is judged to be due to the direct physiological effects of a general medical condition” (APA, 2000, p. 401). Symptoms may resemble those of any of the mood episodes, and may lead to a distinction in subtype. These include With Depressive Features, With Major Depressive-Like Episode, With Manic Features, or With Mixed Features. Substance-Induced Mood Disorder is reserved for those disorders that exhibit similar disturbance in mood directly linked to the physiological effects of a substance. There must be evidence that the symptoms developed in direct association with substance intoxication, or within a month of withdrawal from a substance. The disturbance may not be better accounted for by a mood disorder not related to ingestion of a substance. Specifiers include With Depressive Features, With Manic Features, With Mixed Features, With Onset During Intoxication, and With Onset During Withdrawal. Mood Disorder Not Otherwise Specified is the diagnosis reserved for those disorders whose symptoms reflect disturbance of mood, but fail to meet the criteria for any other specific mood disorder (APA, 2000).

In conclusion, it is likely the mental health counselor will encounter a client presenting with symptoms resembling those used to delineate mood episodes and subsequently the mood disorders. A working knowledge of the DSM-IV-TR diagnostic criteria will assist the counselor to employ effective treatment services.

References

Bipolar Disorders in DSM-IV-TR: Diagnosis and Treatment Matching

Gary G. Gintner

Overview
Bipolar Disorders have undergone major modifications in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychiatric Association, 2000). Many of these changes were driven by accumulating research evidence that suggested particular features of a mood episode could predict course and potential treatment response (APA, 2000). For example, a pattern of rapid cycling (i.e., four or more mood episodes in the past year) is associated with a chronic course and a poor response to lithium (Jefferson, 1995). As a result, the diagnosis of bipolar disorders in DSM-IV-TR has become more descriptive with the addition of new types (Bipolar I or II) and mood specifiers (e.g., With Rapid Cycling). The purpose of this digest is to present on overview of Bipolar I and II Disorders in DSM-IV-TR and to discuss treatment implications in relation to diagnostic features.

Diagnosis of Bipolar Disorders

Types of Mood Episodes
The diagnosis of Bipolar Disorders entails assessing both current and past mood episodes. The DSM-IV-TR (APA, 2000) describes four basic types of mood: Manic, Hypomanic, Major Depressive, and Mixed. A Manic Episode is characterized by at least a week of elevated, expansive or irritable mood plus three other manic symptoms (four if only irritable mood is present). These symptoms must be so severe that they necessitate hospitalization, occur with psychotic features or cause marked impairment in social or occupational functioning. A Hypomanic Episode has the same symptoms as a Manic Episode except that the mood episode can be briefer (i.e., four days) and the symptoms are not so severe that they markedly impair functioning (e.g., no need for hospitalization). A Major Depressive Episode requires five depressive symptoms that persist for at least two weeks.

Finally, a Mixed Episode entails a week or more of both Manic and Major Depressive symptoms nearly every day. For example, a typical symptom picture might include racing thoughts, grandiosity, increased energy, irritability, hopelessness, and depressed mood (Swann, 1995). Once a careful history of these mood episodes has been taken, the mental health counselor can then determine whether the client’s symptoms meet criteria for either Bipolar I or II Disorder.

Bipolar I Disorder
Bipolar I Disorder is characterized by a history of at least one Manic or Mixed Episode. The mental health counselor should be sure that the symptoms were not simply the result of a medical condition e.g., stroke, epilepsy, HIV or a substance; e.g., AZT, thyroid medications, anti-depressant medication (Jefferson, 1995). Diagnostic coding of Bipolar I is determined by noting the type of current mood episode from the following categories:

Single manic episode. This code name is used when the individual presents with a Manic or Mixed Episode but
has no previous history of any type of mood episode.

Most recent episode manic. These individuals are currently in a Manic Episode but also have a history of some kind of mood episode.

Most recent episode hypomanic. Instead of grandiosity and pressured speech which is more characteristic of mania, these individuals present with toned-down manic symptoms such as uncritical self-confidence and a loud tone of voice (APA, 2000).

Most recent episode mixed. About 30% of manic-like episodes are of the Mixed type. In comparison to a Manic Episode, those who present in a Mixed Episode may have more hostility and cognitive impairment. Incidence is higher in those who abuse substances, have neurological problems, or are female (Swan, 1995).

Most recent episode depressed. Depressive Episodes either follow or precede Manic Episodes about 60% to 70% of the time (APA, 2000). In comparison to pure Major Depressive Disorder, depression in Bipolar Disorders is more likely to present with increases in sleeping and eating, psychomotor retardation, and delusions (Coryell et al., 1995).

Most recent episode unspecified. This is used if the current mood episode has not yet met duration criteria. For example, mixed symptoms are being assessed on the third day of the episode.

Specifiers. The current episode can be further delineated by the addition of specifiers indicating severity of the mood episode e.g., mild, moderate, etc., as well as other specifiers if present: With Catatonic Features e.g., excessive motor activity, posturing, and With Postpartum Onset (within four weeks of giving birth). If the current mood episode is depressed, then any of the major depressive disorder specifiers can be used (e.g., Melancholic, Chronic, Atypical) (APA, 2000).

Specifiers also have been added to note the course or pattern of mood episodes over time. These include: With Rapid Cycling, With Seasonal Pattern (seasonality of depression only), and With or Without Full Interepisode Recovery (presence or absence of symptoms between the last two mood episodes) (APA, 2000). The following is an example of how a diagnosis might appear: 296.62 Bipolar I Disorder, Most recent Episode Mixed, Moderate, With Postpartum Onset, With Full Interepisode Recovery.

**Bipolar II Disorder**

In Bipolar II Disorder there is one or more Major Depressive Episodes along with a history of at least one Hypomanic Episode. A major distinction from Bipolar I Disorder is the absence of any history of manic or mixed episodes. Because this means that episodes of elevated mood are not as extreme, clients may not recall episodes as accurately as those with Manic Episodes. Furthermore, they typically seek treatment during their depressive phase which further obfuscates the presence of a Bipolar Disorder. Misdiagnosis can be particularly problematic because, like Bipolar I Disorder, the use of antidepressants can precipitate mania or rapid cycling (Jefferson, 1995). As a result, it is particularly important for the mental health counselor to collect collateral data from medical records and family members.

Bipolar II Disorder can be further specified by adding the current mood episode (i.e., Hypomanic or Depressed). If the current mood is depressed, the same specifiers listed above for Bipolar I can be used (e.g., With Postpartum Onset). Likewise, the same course specifiers for previous episodes can be added; e.g., With Rapid
Cycling. A sample diagnosis might be: 296.89 Bipolar II Disorder, Depressed, Moderate, With Rapid Cycling, With Full Interepisode Recovery.

**Treatment Implications**
Lithium was once considered the miracle drug for Bipolar Disorders. However, more recent longitudinal studies indicate that only 35% of those who regularly take lithium are considered to have a favorable outcome (Goldberg, Harrow, & Grossman, 1995; Jefferson, 1995). Findings like these have had clinical researchers reexamine alternative medications as well as the role of psychosocial treatments. Recent reviews of lithium efficacy have begun to delineate bipolar features that predict good outcome. Lithium is most effective in young and middle-aged adults who present with acute mania or acute bipolar depression (Jefferson, 1995). However, lithium is only minimally effective in those who are either adolescent or elderly, or who have any of these features: currently in a mixed episode, presence of rapid cycling, mania that is secondary to a medical condition, or comorbid substance use. The drug of choice if any of the above features are present is an anti-convulsant such as divalproex (Depakote) (Goldberg, et al., 1995; Swan, 1995).

**Psychosocial Treatments**
A number of psychosocial factors have been associated with mood episode onset and severity. These include moderate to severe stress, introversion, low social support, and obsessiveness (Solomon, Keitner, Miller, Shea, & Keller, 1995; Swendsen, Hammen, Heller, & Gitlin, 1995). In line with these findings, a number of counseling interventions have been found to enhance long-term outcome when combined with medications. For example, family, couple, and group therapy are each associated with decreased hospitalizations and increased rates of recovery (Solomon et al., 1995). Cognitive-behavior therapy for medication compliance also has been associated with fewer hospitalizations (Solomon, et al., 1995).

**Conclusion**
The diagnosis of bipolar disorders in DSM-IV-TR (APA, 2000) requires careful specification of mood features. While the diagnostic process can be complex, one major advantage is that treatments can be more systematically matched to the client’s particular symptoms. Likewise, research findings are indicating that counseling interventions have a critical role in the overall treatment of Bipolar Disorders.

**References**


