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 learn to

- understand the general use of the DSM-IV-TR for psychodiagnosis
- 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 II: The DSM-IV-TR Anxiety Disorders (vol.2), pages 3-34

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The DSM-IV-TR Anxiety Disorders (vol2)

Patricia Polanski

The category Anxiety Disorders in the DSM-IV-TR (APA, 2000) contains the following disorders: Panic Disorder Without Agoraphobia, Panic Disorder With Agoraphobia, Agoraphobia Without History of Panic Disorder, Specific Phobia, Social Phobia, Obsessive-Compulsive Disorder, Posttraumatic Stress Disorder, Acute Stress Disorder, Generalized Anxiety Disorder, Anxiety Disorder Due to a General Medical Condition, Substance-Induced Anxiety Disorder, and Anxiety Disorder Not Otherwise Specified.

Since Panic Attacks and Agoraphobia occur within the context of several of these disorders, the beginning of this chapter offers descriptive information about panic attacks and agoraphobia. This information is useful in helping the mental health counselor begin to discern whether or not the symptoms described by the client match the characteristics for these two central features.

Panic attacks can appear as part of the presentation of a variety of anxiety disorders. A panic attack is a discrete period in which there is the sudden onset of intense apprehension, fearfulness or terror, feelings of impending doom, and fear of “going crazy” or losing control. Also present are physiological symptoms such as shortness of breath, palpitations, chest pain or discomfort, and choking or smothering. Panic attacks are further differentiated into three types according to the relationships between the onset of the attack and the presence or absence of situational triggers. These types are: unexpected (uncued) panic attacks, situationally bound (cued) panic attacks, and situationally predisposed panic attacks. Agoraphobia refers to anxiety about being in places or situations where escape might be difficult or embarrassing or where help may not be available in the event of a panic attack or the onset of panic-like symptoms. This anxiety typically leads to the pervasive avoidance of characteristic clusters of situations that may include being alone at home or outside the home, being in a crowd of people or standing in line, being on a bridge or in an elevator, and traveling in a bus, train, or automobile. Further differentiation is made with regard to whether or not the situations are completely avoided, endured with marked distress about having a panic attack or panic-like symptoms, or require the presence of a companion (APA, 2000).

Panic Disorder involves the presence of recurrent unexpected panic attacks about which there is persistent concern. Agoraphobia may or may not occur along with Panic Disorder. Specific Phobia is a marked and persistant fear of clearly discernible objects or situations. Social Phobia is a marked and persistant fear of social or performance situations. In both of these disorders, the exposure to the feared object or situation invariably provokes an immediate anxiety response, that may take the form of a panic attack.

Obsessive-Compulsive Disorder is characterized by recurrent obsessions i.e., persistent ideas, thoughts, impulses or images which cause one or more of the following: marked anxiety or distress or compulsions, or repetitive behaviors which serve to neutralize anxiety. In addition to causing marked distress, the obsessions or compulsions must be time consuming i.e., take more than 1 hour per day, or significantly interfere with
one’s normal routine, occupational functioning, or usual social activities and relationships with others. In adults with this disorder, there is some level of recognition that the obsessions or compulsions are excessive or unreasonable. This requirement does not apply with children who may lack sufficient cognitive ability to make this judgment.

Posttraumatic Stress Disorder involves the development of characteristic symptoms following exposure to an extremely traumatic event. The diagnostic criteria includes specific information regarding the event, the re-experiencing of the event, avoidance of stimuli associated with the trauma, numbing of general responsiveness, and symptoms of increased arousal. Other qualifying features include duration (more than 1 month) of the disturbance and the extent of distress or impairment caused by the disturbance. The symptoms of Acute Stress Disorder are similar to those of Posttraumatic Stress Disorder. However, with Acute Stress Disorder the disturbance lasts for at least two days and does not persist beyond four weeks after the traumatic event.

Generalized Anxiety Disorder is characterized by excessive anxiety and worry about a number of events or activities, occurring more days than not, over a period of at least six months. This excessive anxiety and worry results in the individual having difficulty controlling worrisome thoughts and keeping those thoughts from interfering with attention to everyday tasks.

The main feature of Anxiety Disorder Due to a General Medical Condition is clinically significant anxiety that is the direct physiological consequence of a general medical condition as evidenced by client history, physical examination, or laboratory findings. Substance-Induced Anxiety Disorder involves the presence of prominent anxiety symptoms that are due to the direct physiological effects of a substance: i.e., a drug of abuse, a medication, or toxin exposure. Finally, the category, Anxiety Disorder Not Otherwise Specified, includes disorders with prominent anxiety or phobic avoidance that do not meet criteria for any specific anxiety disorder.

Medical/Physical Considerations
Barlow (1988) points out that the study of anxiety and its disorders needs to proceed with a full consideration and integration of biological and psychological factors. Two concepts related to this idea are worth noting here. The first concept has to do with the use of medications in treatment and the second is related to the physiological symptoms associated with panic attacks.

In the short-term treatment of Panic Disorder, three drug classes have been found to be effective—the tricyclic antidepressants, the monoamine oxidase inhibitors, and the benzodiazepines (Schatzberg & Ballenger, 1991). Cases of severe Panic Disorder may be associated with particularly high morbidity as evidenced by increased rates of alcohol abuse, suicidal behavior, depression and financial dependence. According to Schatzberg & Ballenger, the decision to use pharmacological therapies should be based on whether or not the individual meets the criteria for acute treatment. These criteria include recent severe or frequent panic attacks or generalized anxiety, clear morbidity, secondary comorbid disorders and significant family history of suicide or alcohol abuse. While the literature is clear in delineating the efficacy of behavioral treatments, particularly in vivo exposure in the alleviation of phobic avoidance behaviors, the effectiveness of behavioral treatments in the alleviation of panic attacks remains uncertain (Laraia, Stuart, & Best, 1989). There also is research indicating that cognitive-behavioral approaches are more effective than medication alone in maintaining treatment gains over time (Meichenbaum, 1995). Given the complexity and multifaceted nature of the panic/agoraphobia syndrome, it is likely that a combination of pharmacological and psychological approaches may provide the most effective treatment; for example, psychological treatments that encourage the individual to confront fear-
provoking cues serve as an appropriate adjunct to medication in cases where persons continue to exhibit some avoidance behavior despite having their panic attacks blocked.

Research data compiled over the last decade have indicated that Obsessive-Compulsive Disorder (OCD) is relatively common and frequently co-exists with other psychiatric disorders (Zetin & Kramer, 1992). As with Panic Disorder, psychological and biological approaches have been applied to understanding OCD, and it appears that a combination of psychological and pharmacological treatments are useful. Long-term treatment with medication seems to be required for most individuals with OCD. In vivo exposure with response prevention is the treatment of choice for compulsions, and exposure in imagination with thought stopping appears to be the treatment of choice for obsessions. The efficacy of the anti-depressant medication clomipramine in treating OCD is established more definitively than that of any other drug (Zetin & Kramer, 1992). The second concept to be noted here is related to the phenomenon of interpreting, or misinterpreting, bodily sensations in the course of panic attacks. Because the individual is reporting the experience of certain physical symptoms, it becomes prudent for the counselor to have the client obtain a thorough physical examination in order to further understand any medical conditions that could simulate anxiety symptoms (Meichenbaum, 1995). In addition, by making this recommendation the mental health counselor demonstrates respect for the client’s perceptions while offering an appropriate way to check those perceptions.

References


The DSM-IV-TR Somatoform Disorders

Kathy Short Phillips & Carmen R. Pyles

Often encountered in general medical settings, the DSM-IV-TR (APA, 2000) Somatoform Disorders are characterized by the presence of physical symptoms which suggest a general medical condition. These symptoms, however, are not fully explained by a medical condition, the direct effects of a substance, or another mental disorder. Even in the absence of a diagnosable general medical condition, these symptoms, which are not intentionally produced, cause significant distress or impairment in important areas of an individual’s functioning. Although grouped together, these disorders do not necessarily share etiological or mechanical components. The DSM-IV-TR Somatoform Disorders include Somatization Disorder, Undifferentiated Somatoform Disorder, Conversion Disorder, Pain Disorder, Hypochondriasis, Body Dysmorphic Disorder, and Somatoform Disorder Not Otherwise Specified.

Somatization Disorder

Individuals diagnosed with Somatoform Disorder exhibit a pattern of multiple somatic complaints for which medical treatment is sought. Complaints generally begin before the age of 30 and continue for many years, without reported symptoms. Other diagnostic criteria involve the nature of reported symptoms. The associated pain is generally related to at least four different bodily sites or functions. At least two gastrointestinal symptoms (other than pain) must be reported; nausea and bloating are common. There must be at least one symptom associated with sexual intercourse or reproduction, other than pain. Finally, there must be at least one pseudoneurological symptom or deficit which suggests a neurological condition not limited to pain. These may include conversion symptoms such as impaired coordination or balance, paralysis or localized weakness, throat problems, aphonia, urinary retention, hallucinations, loss of sensory perceptions, seizures, dissociative symptoms, or loss of consciousness other than fainting. Although general medical conditions exist concurrently with Somatization Disorder, the following distinguishing features suggest a diagnosis of the latter: involvement of multiple organ systems, and early onset and chronic course without substantiating medical or laboratory evidence. Whenever a general medical condition is found to coexist with Somatization Disorder, the complaints and impairment are excessive. There are a number of implications for caregivers concerning Somatization Disorder. The exaggeration and recurrence of symptoms, along with anxiety and depressive mood, should alert mental health counselors and medical personnel to the possibility of Somatization Disorder. Thorough review of medical treatments and hospitalizations generally reveal a distinct pattern of frequent somatic complaints. Individuals with Somatization Disorder often seek medical treatment from several physicians concurrently, and may undergo a variety of unnecessary medical procedures, including exploratory surgery. Several other disorders frequently associated with Somatization Disorder are Major Depression, Panic Disorder, Substance-Related Disorders, and Personality Disorders.

Undifferentiated Somatoform Disorder

Undifferentiated Somatoform Disorder is diagnosed when one or more physical complaints persist for at least six months. The disturbance exhibits the other common characteristics of Somatoform Disorders, and is not better accounted for by another mental disorder, including other Somatoform Disorders. This disorder is often diagnosed when the full criteria of another Somatoform Disorder or general medical condition are not met. Commonly reported physical symptoms associated with Undifferentiated Somatoform Disorder include fatigue, appetite loss, and gastrointestinal and urinary complaints.
Conversion Disorder
The diagnosis of Conversion Disorder is made when an individual presents with symptoms or deficits affecting voluntary motor or sensory function that suggest, but are not fully explained by, a neurological or other general medical condition. These pseudoneurological symptoms are not due to substance use, do not occur exclusively during another Somatization Disorder, and are not better accounted for by another mental disorder. The Conversion Disorder diagnosis is not made if symptoms are limited to pain or sexual dysfunction, or demonstrate a culturally sanctioned experience. Conversion symptoms are specified by the following subtypes: With Motor Symptom or Deficit, With Sensory Symptom or Deficit, With Seizures or Convulsions, and With Mixed Presentation.

Conversion symptoms tend to follow an individual’s conceptualization of a condition and are often inconsistent. For example, “paralysis” may disappear during a moment of inattention with apparent normal muscle tone and reflexes. Since conversion symptoms do not conform to known anatomical pathways and physiological mechanisms, there are typically no objective signs or supporting medical tests. Interestingly, however, individuals who are more knowledgeable of the medical field tend to exhibit symptoms which closely resemble neurological or general medical conditions. Medically naive individuals and those of rural populations and lower socioeconomic status report Conversion Disorder at a higher rate, with more implausible symptoms.

One criteria for diagnosing Conversion Disorder is the association of psychological factors. For example, conflict or other stressors tend to initiate or exacerbate the symptoms or deficits. Although the DSM-IV-TR (APA, 2000) criteria are not specific regarding psychological constructs, anxiety reduction and the evasion of responsibility have been hypothesized as unconscious motives underlying conversion symptoms. The diagnosis of Conversion Disorder in individuals should be made cautiously, or provisionally. General medical conditions are sometimes discovered years after Conversion Disorder is diagnosed. For example, neurological conditions, such as multiple sclerosis, myasthenia gravis, and idiopathic or substance-induced dystonia are often misdiagnosed as Conversion Disorder. However, both neurological and general medical conditions may coexist with Conversion Disorder. To correctly diagnose Conversion Disorder, therefore, a thorough medical evaluation is essential. A history of unexplained somatic complaints or dissociative symptoms are strong indicators of Conversion Disorder, along with a relative lack of concern (“la belle indifference”) over the presenting symptoms.

Pain Disorder
Pain Disorder is unlike other Somatoform Disorders because the client is truly experiencing pain in one or more anatomical sites. The client’s unintentional pain results in extreme distress or impairment in social and occupational functioning. Problems with family and friends are common. Psychological factors play a large role in the onset, severity, exacerbation, or maintenance of the pain. The pain becomes a major focus of the individual’s life, which may result in substantial use of medications to cope with the pain and daily life activities. Attempts to treat the pain may cause additional problems and more pain; e.g., use of nonsteroidal anti-inflammatory drugs resulting in gastrointestinal distress.

There are three subtypes of Pain Disorder:

(1) Pain Disorder associated with psychological factors,
(2) Pain Disorder associated with both psychological factors and a general medical condition and
(3) Pain Disorder with a general medical condition.
The latter subtype is not considered a mental illness and is diagnosed on Axis III. Pain Disorder can be further diagnosed with acute and chronic specifiers.

**Hypochondriasis**
A preoccupation with fears of having, or the idea that one has, a serious disease is the main feature of Hypochondriasis. The individual manifests in his or her mind one or more bodily signs or symptoms of a particular disease. When a physician thoroughly examines such a client, a general medical condition that would account for the person’s concerns about the disease is not found although a coexisting general medical condition may be present. Other symptoms include impairment in social, occupational, or other important areas of functioning. Mental health counselors should specify *With Poor Insight* if during the episode the person does not recognize that their concern about the disease is unreasonable. Differential diagnoses typically include Generalized Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, a Major Depressive Episode, Separation Anxiety, or another Somatoform Disorder.

**Body Dysmorphic Disorder**
Body Dysmorphic Disorder is characterized by a preoccupation with a defect in appearance that is either imagined or barely observable and results in extremely unreasonable concern. The individual is often markedly distressed over the ‘deformity’ and often finds it difficult to control his or her preoccupation. Common complaints include imagined or slight flaws on the face or head such as hair thinning, acne, scars, and facial asymmetry. This disorder also is characterized by frequent mirror checking, excessive grooming behavior, and may occupy hours of the person’s time. Anxiety may cause avoidance of work and social situations and may result in extreme isolation. Social Phobia, Obsessive Compulsive Disorder and Major Depressive Disorder are often associated with this illness. Differential diagnoses may include Anorexia Nervosa and Avoidant Personality.

**Somatoform Disorder NOS**
Finally, Somatoform Disorder Not Otherwise Specified is a category that includes disorders with somatoform symptoms that do not meet the criteria for any of the other disorders in this section. For example, the disorder Pseudocyesis is diagnosed when a person falsely believes that she is pregnant. She may have physical signs of pregnancy such as abdominal enlargement, reduced menstrual flow, amenorrhea, and labor pains at the expected delivery date. Other examples of Somatoform Disorder NOS include disorders involving non-psychotic, hypochondriacal symptoms of less than six months duration, or disorders that involve unexplained physical complaints of less than six months which are clearly not due to another mental disorder (APA, 2000).

**References**


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**The DSM-IV-TR Dissociative Disorders**

Max Marie McIntosh

The category Dissociative Disorders in the DSM-IV-TR (APA, 2000) contains the following disorders: Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder, Depersonalization Disorder, and Dissociative Disorder Not Otherwise Specified. Dissociation is a disruption in the normally integrated functions of consciousness, memory, identity, or perception of the environment (APA, 2000). The disturbance may be sudden or gradual, transient or chronic.

**Dissociative Amnesia**

Dissociative Amnesia involves one or more episodes of inability to recall important personal information that is too extensive to be explained by ordinary forgetfulness. The information forgotten is usually of a stressful or traumatic nature and the memory impairment is reversible. One epidemiological study found that Dissociative Amnesia was the most common dissociative disorder in a random sample of the general population, with a lifetime prevalence of 7.0% (Ross, 1991). It can occur in any age group and usually presents as a retrospective gap in memory. There are five different types of amnesia: localized, selective, generalized, continuous, and systematized. In the most common types, localized and selective amnesia, memories from a circumscribed time period (often following a profoundly disturbing event) are unable to be recalled. In localized amnesia, no memories of the lost time period can be recalled, whereas in selective amnesia, some but not all of the events of that time period can be recalled. Generalized amnesia, in which the person is unable to recall any personal history at all, is rarer. Continuous amnesia is generalized amnesia with a disruption in the ongoing process of
memory storage, so that the client is unable to recall any events of either the past or the present. **Systematized amnesia** is a loss of memory confined only to very specific types of information, such as those memories relating to a particular person, one’s family, or a specific location or activity, again frequently associated with an overwhelming life event.

Amnesia can also occur as a consequence of neurological conditions such as epilepsy, brain injury, delirium, or dementia, general medical conditions, and substance or medication effects. Dissociative Amnesia is also among the diagnostic criteria for Dissociative Fugue, Dissociative Identity Disorder, Dissociative Disorder Not Otherwise Specified, Somatization Disorder, Acute Stress Disorder, and Posttraumatic Stress Disorder. These mental disorders, along with general neurological or medical causes, must be ruled out in order to diagnose Dissociative Amnesia (APA, 2000, 1994).

**Dissociative Fugue**

Dissociative Fugue is characterized by sudden and unexpected travel away from one’s customary place of daily activities, and is accompanied by an inability to recall some or all of one’s past, confusion about personal identity, or the adoption of a new identity. The onset is usually related to overwhelming stress or trauma, and recovery is rapid, although Dissociative Amnesia may persist. Dissociative Fugue is most frequently found in adults and is much less common than Dissociative Amnesia, with an estimated prevalence rate of only 0.2% in the general population. It may be more common, however, in settings of war or other highly violent and socially disruptive incidents (Putnam, 1985). As with Dissociative Amnesia, it is important to distinguish Dissociative Fugue from similar symptoms caused by neurological, medical, or other psychiatric conditions and substance abuse or medication effects. Because Dissociative Fugue incorporates the symptoms of both Dissociative Amnesia and Depersonalization Disorder, these should not be diagnosed concurrently (APA, 2000). Dissociative Amnesia and Dissociative Fugue are treated similarly, using a trauma framework which assumes the individual took flight or dissociated memories were cognitively or affectively intolerable (Loewenstein, 1996). In the crucial first phase of treatment, the client is assisted in achieving enough safety and stability to face the second phase of retrieving and processing the forgotten memories. In the final phase, resolution is achieved when the previously dissociated material is integrated into normal life experiences. The mental health counselor can be instrumental in providing group therapy, psycho-education, and individual counseling for clients with these disorders. Although hypnosis and even drug-facilitated interviews may be used by some clinicians, these techniques are controversial because of the potentials for both memory contamination and further traumatization by premature recovery of memories.

**Dissociative Identity Disorder**

Dissociative Identity Disorder (DID), formerly Multiple Personality Disorder in the DSM-III, is characterized by the existence of two or more distinct identities or personality states, each with its own relatively enduring pattern of perceiving, relating to, and thinking about the self and the environment. At least two of these identities must recurrently take control of the person’s behavior and the person is also unable to recall important personal information as in Dissociative Amnesia. Identity, memory, affect, sensation, behavior, consciousness, or a combination of any of these may be dissociated (APA, 2000).

The typical client with Dissociative Identity Disorder is a female in her 20’s or 30’s with a long history of involvement in the mental health, social service, medical, and legal systems (Ross, 1997). Previous diagnoses may include Somatization Disorder, Posttraumatic Stress Disorder or other Anxiety Disorders, Eating Disorders, Borderline or other Personality Disorders, Mood Disorders, Schizophrenia, and Substance-Related Disorders.
Although some of these diagnoses, particularly Schizophrenia and Bipolar Disorder, may be erroneous, researchers have found co-morbidity rates above 60% for Mood Disorders, Anxiety Disorders, Somatization Disorders, and Substance Abuse (Ross, 1997). The Dissociative Identity Disorder diagnosis tends to be surrounded by controversy in light of its recent sharp rise in reported cases and the high hypnotizability and suggestibility of these clients.

The prognosis for clients with Dissociative Identity Disorder is surprisingly good given the apparent severity of the disorder. DID rarely remits spontaneously and is usually not resolved in a treatment that fails to address it directly (Kluft, 1996). Although few well-controlled studies of treatment outcome exist, some clinicians estimate that approximately two-thirds of these clients can attain a stable integration or fusion of personalities, with an average length of treatment of three to five years (Ross, 1997). Because “the basic principle of the treatment of DID is that it is the treatment of a person,” (Ross, 1997, p. 264) the mental health counselor is an ideal treatment provider. Counseling’s emphasis on healthy development, collaboration with the client, developing trust and a positive treatment alliance, building on client strengths, improving communication and life management skills, and respect for the client are all integral to treatment of this disorder (Ross, 1997). Treatment approaches include, but are not limited to, cognitive, behavioral, psychodynamic, and ego state therapy, hypnosis, skillbuilding in emotional containment, coping strategies, communication and relationship management, expressive therapies (such as art, movement, dance, sand tray, occupational, and recreation therapy), psycho-educational and other group therapies, and even limited use of psychopharmacology for temporary symptom control.

Depersonalization Disorder
The essential feature of Depersonalization Disorder is persistent and recurrent episodes of a feeling of detachment or estrangement from one’s self. Although reality testing is intact, such persons may feel as if they are outside their body, living in a dream or movie, or that they have become an automaton. Derealization, the sense that the external world is strange or unreal, is common as well. Because depersonalization is a common experience, the disorder should be diagnosed, as with any other DSM-IV-TR disorder, only if there is marked distress or impairment in functioning (APA, 2000). Depersonalization is also the third most common reported psychiatric symptom and is found in Schizophrenia, Panic Disorder, Phobias, Acute or Posttraumatic Stress Disorder, other Dissociative Disorders, Borderline Personality Disorder, other mental disorders, and general medical, neurological, or substance-induced conditions (Cattell, 1966). The presence of any of these disorders precludes a diagnosis of Depersonalization Disorder. Depersonalization Disorder by itself is exceedingly rare and is often accompanied by depression and suicidal behavior (Coons, 1996).

Treatment efficacy research results for Depersonalization Disorder are inadequate because of the disorder’s rarity and tendency to remit spontaneously. Popular approaches include behavior therapy, reality therapy, and individual counseling focused on improving self-esteem. Any accompanying depression and suicidality also must be addressed. As some success has been reported using selective serotonin re-uptake inhibitors (SSRIs, e.g. fluoxetine), the mental health counselor may wish to consider referral to a physician for a medication trial (Hollander et al., 1990).

Dissociative Disorder Not Otherwise Specified
Dissociative Disorder Not Otherwise Specified is characterized by the presence of a dissociative symptom that does not meet the criteria for any specific Dissociative Disorder. Examples include presentations similar to Dissociative Identity Disorder in which either amnesia or the presence of distinct personality states is absent;
culturespecific dissociative trances; or dissociation subsequent to brainwashing or similar prolonged, intense, coercive persuasion.

**Treatment Depends on the Etiology**
In summary, the mental health counselor can be significantly helpful to clients with Dissociative Disorders and knowledge of these disorders should be an integral component of the mental health counselor’s clinical preparation.

**References**


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Sexual Dysfunctions

John C. Bandy

The DSM has gone through several revisions and publications. During that time period the classification of Sexual Dysfunction and its place in the DSM has varied as well. DSM-III had a Psychosexual Disorder section which contained four diagnoses: Gender Identity Disorders, Paraphilias, Psychosexual Disorders, and a residual class of Psychosexual Disorders that had two categories: Ego-dystonic Homosexuality, and Psychosexual Disorders Not Elsewhere Classified (APA, 1980). DSM-III-R included a Gender Identity Disorder section composed of Gender Identity Disorder of Childhood, Transsexualism Gender Identity Disorder of Adolescence or Adulthood, Non-Transsexual Type, and Gender Identity Not Otherwise Specified. DSM-III-R also had a sexual disorders section which contained Paraphilias, Sexual Dysfunctions, and other Sexual Disorders (APA, 1987). DSM-IV was published in 1994 (and revised in 2000) with the Sexual Disorders divided into seven sections: Sexual Desire Disorders, Sexual Arousal Disorders, Orgasmic Disorders, Sexual Pain Disorders, Sexual Dysfunction Due to a General Medical Condition, Substance-Induced Sexual Disorder, and Sexual Dysfunction Not Otherwise Specified. These sexual dysfunctions are characterized by a disturbance in sexual desire. As varied as the dysfunctions are, so too are the therapies that mental health counselors have at hand to help their clients, including systematic desensitization and the “post-modern approach” (Lopiccolo & Friedman, 1988).

Diagnosis of Sexual Dysfunction

Sexual Desire Disorder
The Sexual Desire Disorders (SDDs) are divided into Hypoactive Sexual Desire Disorder (HSDD) and Sexual Aversion Disorder (SAD). The necessary feature of HSDD is an insufficiency or absence of sexual fantasies and sexual desire. The disturbance must cause marked distress or interpersonal difficulty and the dysfunction must not be better accounted for by another DSM-IV-TR Axis I disorder. HSDD might be global and related to all sexual behavior or may be limited to one sexual act (intercourse) by one partner. The mental health counselor should assess both partners to rule out an excessive need by one partner which might cause the other to appear hypoactive (APA, 2000). The basic characteristic of SADs is the unwillingness to engage in, and the active avoidance of, genital sexual contact with a sexual partner. When being assessed, clients report anxiety, fear, or disgust when a sexual encounter presents itself with their partner. Two aspects of the aversion might be genital secretions or vaginal penetration. Furthermore, some individuals might have negative responses to all sexual activity, including kissing and caressing (APA, 2000).

Sexual Arousal Disorders
Sexual Arousal Disorders contain Female Sexual Arousal Disorder (FSAD) and Male Erectile Disorder (MED). FSAD is a persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response to sexual excitement (APA, 2000). This disorder may be accompanied by Sexual Desire Disorder and Female Orgasmic Disorder. MED is the perpetual or recurrent inability to achieve, or to continue until completion of the sexual activity, a satisfactory erection. Although some males may not be able to have an erection during any sexual encounter, some may report having an erection before intercourse and losing tumescence before penetration. Other males will report only having an erection during self-masturbation or when awakening (APA, 2000).
**Orgasmic Disorders**
The Orgasmic Disorders consist of Female Orgasmic Disorder (FOD), Male Orgasmic Disorder (MOD), and Premature Ejaculation Disorder (PED). FOD is a continuous delay in, or absence of, orgasm following a normal sexual encounter in females; MOD is the equivalent in males. The cause of the disorder is not clear. The male’s body image, self-esteem, and sexual relationships may be severely affected as a result of this disorder. The essential feature of PED is the early onset of orgasm and ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person desires it. The mental health counselor should take into account the client’s age, the newness of sex, and the frequency of sexual acts (APA, 2000).

**Sexual Pain Disorders**
Sexual Pain Disorders consist of Dyspareunia and Vaginismus. The basic feature of Dyspareunia is genital pain associated with sexual intercourse. Usually, this disorder is treated in a general medical setting first. Genital pain during coitus may lead to sexual relation problems and sexual avoidance. The major feature of Vaginismus is the involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration is attempted. This disorder is found usually more often in younger females who have a negative opinion of sex (APA, 2000).

**Sexual Dysfunction Due to a General Medical Condition**
The central feature of Sexual Dysfunction Due to a General Medical Condition is the presence of a clinically significant sexual dysfunction judged to be due exclusively to the direct physiological effects of a medical condition (APA, 2000). The sexual dysfunction must be related solely to a general medical dysfunction. A careful and comprehensive assessment of multiple factors is necessary to make this judgment.

**Substance-Induced Sexual Dysfunction**
A Substance-Induced Sexual Dysfunction is distinguished from a primary Sexual Dysfunction by “considering onset and course” (APA, 2000). Characteristics can include impaired desire, impaired arousal, impaired orgasm, or sexual pain. Substance-Induced Sexual Dysfunction is associated with intoxication with alcohol, amphetamines, cocaine, opioids, sedatives, hypnotics, and anxiolytics. Prescribed medications like antihypertensives, anti-depressives, and anabolic steroids also can cause this dysfunction (APA, 2000).

**Treatment**
There are many treatment options available to the mental health counselor in working with sexual dysfunctions. Loppicolo and Friedman (1988) advocate integrating gestalt, family of origin, and a systems approach. McCarthy (1995) has developed a cognitive-behavioral approach that focuses on understanding and changing inhibited sexual desires. Both medications and surgical interventions are used increasingly often as effective therapeutic adjuncts (Rosen & Leiblum, 1995). The key to providing therapy for clients is to match the appropriate therapy with the sexual problem. Assessing the etiology of the sexual dysfunction is complex, but is an important part of treatment. Many issues; e.g. self-esteem, depression, sexual abuse, anxiety, and physiological problems, can contribute to these disorders. Sexual dysfunction may create issues such as lowered self-esteem, depressive mood, and conflictual relationships.

**References**


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**Paraphilias**

Kevin R. Sidden

According to the DSM-IV-TR (APA, 2000), The essential features of a Paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving

  1. nonhuman objects,
  2. the suffering or humiliation of oneself or one’s partner, or
  3. children or other nonconsenting persons that occur over a period of at least 6 months.

Paraphilia is a term used to encompass several disorders including Exhibitionism, Fetishism, Frotteurism, Pedophilia, Sexual Masochism, Sexual Sadism, Voyeurism, Transvestic Fetishism, and Paraphilia Not Otherwise Specified. An individual may be diagnosed for more than one paraphilic disorder. In addition, Gender Identity Disorder, Personality Disorders, and other sexual dysfunctions may coexist.

**Exhibitionism**

The major feature of Exhibitionism is exposing one’s genitalia to a stranger, which may include masturbation during exposure, or the individual may fantasize about Exhibitionism while masturbating. In some cases, the individual may have a desire to surprise or shock the observer, whereas in other cases the individual fantasizes that the observer will become sexually aroused (APA, 2000).
Fetishism
In Fetishism, the major characteristic is the use of nonliving objects, which may include but are not limited to underpants, brassieres, stockings, shoes, or other wearing apparel in a sexual act. The individual frequently masturbates while holding, wearing, rubbing, or smelling the fetish object, or the individual may ask the partner to wear an object during sexual encounters (APA, 2000).

Frotteurism
Frotteurism involves touching or rubbing against a nonconsenting person for sexual arousal or pleasure. The activity usually occurs in crowded places where the individual rubs the genitals against the other’s thighs and buttocks or fondles the individual’s genitalia or breasts (APA, 2000).

Pedophilia
Pedophilia involves sexual activity with a prepubescent child, where the pedophile is at least sixteen years old and at least five years older than the child. The individual may derive pleasure from undressing the child, masturbating in front of the child, having direct physical contact, performing cunnilingus or fellatio, or by penetrating the child’s anus, mouth, or genitalia with mouth, fingers, foreign objects, or genitalia. Some individuals may limit their activities to their relatives, some may seek gratification outside the family, and others may choose relatives as well as victims outside the family (APA, 2000).

Sexual Masochism
The paraphilic nature of Sexual Masochism involves the act of being made to suffer or to be humiliated during sexual activity with a partner or during masturbation. The suffering or humiliation may be brought about by being bound, beaten, infibulated (pricked or pierced by sharp objects), electrically shocked, defecated or urinated on during sexual activity. A potentially lethal form of Sexual Masochism is “hypoxophilia,” which is the act of oxygen deprivation during sexual activity by strangulation or suffocation (APA, 2000).

Sexual Sadism
The paraphilic nature of Sexual Sadism involves the act of deriving sexual pleasure and excitement from causing pain and suffering or by humiliating his/her partner during sexual activity. In some cases the sexual sadist may seek out non-consenting partners who are terrified of the sadistic acts, and the sexual sadist seeks total control over the victim. In other cases the individual may pair up with a consenting partner who is diagnosed with Sexual Masochism.

Transvestic Fetishism
In Transvestic Fetishism the paraphilic focus is on the wearing of clothing of the opposite gender (cross-dressing). This disorder has only been diagnosed in heterosexual and bisexual males. When cross-dressing, the male usually imagines himself as both the female and the male partner while masturbating. The degree of cross-dressing ranges from wearing one article of clothing such as a pair of panties or stockings under masculine attire, to complete cross-dressing including makeup and a mastery of feminine mannerisms and body habits. The disorder should not be diagnosed when it occurs exclusively during the course of Gender Identity Disorder (APA, 2000).

Voyeurism
Voyeurism focuses on observing an unsuspecting person while that person is naked, disrobing, or engaging in sexual activity. The observer may achieve orgasm through masturbation while observing, or after the
observation the observer may achieve orgasm through masturbation while revisualizing the incident. The course of Voyeurism tends to be chronic (APA, 2000).

Paraphilia Not Otherwise Specified
The DSM-IV-TR (APA, 2000) indicates that this category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to telephone scatagoria (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on part of the body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).

Gender Identity Disorder
Gender Identity Disorder is characterized by strong and persistent cross-gender identification (not because it is perceived to be culturally advantageous to be the opposite sex), and a persistent discomfort with one’s own sex or the gender role associated with that sex. The disturbance can not be concurrent with a physical intersex condition such as androgen insensitivity syndrome or congenital adrenal hyperplasia. Individuals with the disorder generally refuse to participate in activities associated with the gender role of their sex, and they generally prefer activities associated with the opposite gender role (APA, 2000).

Gender Identity Disorder Not Otherwise Specified
This category is used for coding disorders such as,
1. Intersex conditions (e.g., androgen insensitivity syndrome or congenital adrenal hyperplasia) and accompanying gender dysphoria.
2. Transient, stress-related cross-dressing behavior.
3. Persistent preoccupation with castration or penectomy without a desire to acquire the sex characteristics of the other sex (APA, 2000).

Sexual Disorder Not Otherwise Specified
Sexual disturbances that can not be identified as a specific Sexual Disorder, and are neither a Sexual Dysfunction nor a Paraphilia are included in the category. According to the DSM-IV-TR (APA, 2000), examples include:
1. Marked feelings of inadequacy concerning sexual performance or other traits related to self-imposed standards of masculinity or femininity.
2. Distress about a pattern of repeated sexual relationships involving a succession of lovers who are experienced by the individual as only things to be used.
3. Persistent and marked distress about orientation.

Treatment
The treatment of Paraphilias varies according to the specific disorder or combination of disorders of which the patient has been diagnosed. Paraphilias such as Exhibitionism, Fetishism, Voyeurism, and Transvestic Fetishism are disorders of milder severity and typically do not require extensive treatment. These disorders may be treated on an outpatient basis and individual psychotherapy is sufficient. Other paraphilias which involve violating the rights of nonconsenting persons are of a more serious nature and require more intensive inpatient therapies. Examples of these paraphilias are Frotteurism, Pedophilia, and Sexual Masochism. Traditionally, Pedophilia has been treated from a multi-modal perspective, using a combination of pharmacological medications, cognitive behavioral therapies, and group therapies.
Impulse-Control Disorders

Tricia C. Gagnon and Shawn L. Spurgeon

Impulse-Control Disorders are characterized by the inability to resist an impulse, drive, or temptation to harm oneself or to harm others. The individual usually experiences a feeling of increased tension or arousal before committing the act and relief or pleasure when the act is committed. Afterwards, feelings of guilt or self-reproach may be felt. There are six classifications of impulse disorders in the DSM-IV-TR: Intermittent Explosive Disorder, Kleptomania, Pyromania, Pathological Gambling, Trichotillomania, and Impulse Control Disorder Not Otherwise Specified (APA, 2000).

Intermittent Explosive Disorder

The primary feature of Intermittent Explosive Disorder is the inability to effectively control and resist aggressive impulses that lead to either severe assaultive acts of violence or to property destruction. Generally speaking, there is no psychosocial stressor that precipitates or provokes the act. This diagnosis is only given after other mental disorders have been effectively ruled out; e.g., Antisocial Personality Disorder, Borderline Personality Disorder, a Psychotic Disorder, a Manic Episode, Conduct Disorder, or Attention Deficit/Hyperactivity Disorder. Also, the aggressive episode cannot be due to the physiological effects of a substance
or to a General Medical Condition (APA, 2000). The explosive episode can be perceived as a “spell” by the individual, preceded by a strong sense of tension or increased awareness, and culminating with a sense of relief. The individual also may feel upset, remorseful, or embarrassed about the aggressive act. It is important to distinguish Intermittent Explosive Disorder from purposeful behavior, or malingering. Individuals that malinger are usually trying to avoid responsibility for their behavior. Also, purposeful behavior is distinguished by the presence in the individual of some type of motivational gain in the aggressive act.

**Kleptomania**

Individuals who repeatedly fail to resist the urge to steal items, even though there is no personal need or monetary value in the items they are stealing, may be diagnosed with Kleptomania. There is usually a rise in subjectiveness or tension before the theft and a deep sense of pleasure, gratification, or relief when committing the theft. The stealing is not done for the sake of revenge or to express some type of anger and is not better accounted for in response to a delusion or hallucination. The thefts are not usually preplanned and no concern is given for getting apprehended. Typically, the individual can afford to pay for the stolen items and they will often give the items away or discard them. The stealing is not better accounted for by Conduct Disorder, a Manic Episode, or by Antisocial Personality Disorder. The individual also may hoard the stolen objects and return them at a later date. Generally, individuals with this disorder will avoid stealing when immediate arrest is probable, and the stealing is done without collaboration or assistance from others. This disorder is distinguished from ordinary acts of theft or shoplifting by the fact that there are no ulterior motives that drive the act; the individual is not stealing the items for their usefulness or their monetary value. This diagnosis is only made when all the essential features and characteristics of the disorder are present (APA, 2000).

**Pyromania**

The essential and prevalent feature of Pyromania is the presence of multiple episodes of deliberate and purposeful fire setting. The individual may experience tension or arousal before setting the fire. He or she seems to be fascinated by, interested in, curious about, or attracted to the fire and its situational contexts. Individuals with this disorder may spend time at local fire departments, may become firefighters, and often gain pleasure by watching fires in their neighborhood, or by setting off false alarms. Any type of institution, equipment, or person associated with fire is pleasing to the individual. The individual may set fires so as to be associated with the local fire department (APA, 2000).

Individuals with this disorder usually experience some type of pleasure or gratification when setting the fire, when witnessing the effects of the fire, or when participating in the aftermath of the fire. The fire setting is not done for monetary gain, to express a sociopolitical viewpoint, to hide some other type of criminal activity, to express anger or revenge, or to enhance one’s housing arrangement. The act is not committed in response to a delusion or hallucination, and it does not result from impaired judgment. If the fire setting can be better accounted for by Conduct Disorder, a Manic Episode, or by Antisocial Personality Disorder, the diagnosis of Pyromania is not made. Pyromania must be distinguished from “communicative arson.” Some individuals with mental disorders use fire setting behaviors to communicate a desire or need, usually centered around gaining a change in the nature or location of the services they are receiving. Also, the fire setting may be done by children as a part of their development; e.g., playing with matches, lighters, or fire. When the fire setting is done for profit, sabotage, revenge, or to attract attention or recognition for one’s self, a diagnosis of Pyromania is not given.
**Pathological Gambling**

Individuals with Pathological Gambling may have distortions in thinking that include irrational beliefs, superstitions, and overconfidence. They often cannot stop themselves from gambling, feeling irritable or bored when they try to stop. They are continuously preoccupied with gambling and are constantly seeking “action” because they are frequently restless, energetic, and competitive. They may be workaholics or may wait until a deadline to begin working (APA, 2000). Due to their stressful lifestyle, and the guilt and anxiety they experience due to gambling losses, they often develop stress-related medical conditions such as ulcers, hypertension, migraines, or insomnia (Abbott, Cramer, & Sherrets, 1995). Pathological Gambling is typically chronic with gambling activity increasing during periods of stress or depression. Long-term “chasing” of one’s losses is characteristic of individuals with Pathological Gambling. They feel an urgent need to undo their losses, and may feel anxious and depressed until they are able to gamble again. If they do win while gambling, they may be unable to stop. They typically increase the risks and size of their bets to obtain the same level of excitement experienced in previous wins (Abbott, et al., 1995). Individuals with Pathological Gambling may lie to concerned friends or family to conceal their gambling problem and at other times turn to them for financial help when desperate. They may lose their jobs, homes, and significant relationships as a result of their inability to control their gambling. Antisocial behavior, usually nonviolent, such as forgery, theft, or fraud may occur in order to obtain money to gamble or pay off debts. Attempted suicide is reported in 20% of individuals in treatment for Pathological Gambling. A diagnosis of Pathological Gambling is not made if gambling occurs in the course of Mania or Antisocial Personality Disorder (APA, 2000).

**Trichotillomania**

Individuals with Trichotillomania cannot control the impulse to pull out their own hair. They may pull hair from any place on the body, but the most common areas are the scalp, eyelashes, and eyebrows (APA, 2000). Eyelashes and eyebrows may be absent with a noticeable loss of hair on the crown of the head, with hair left only at the nape of the neck and above the ears. However, most individuals with Trichotillomania make every effort to conceal their hair loss (Rothbaum & Ninan, 1994). Hair pulling episodes may occur briefly throughout the day, or last for hours while in a state of relaxation and distraction while watching television or reading. Hair pulling usually increases under stress, with a feeling of increased tension until the hair can be pulled (APA, 2000). Embarrassment and shame associated with their behavior and appearance cause most persons to deny and to hide their hair pulling from others except for immediate family members (Rothbaum & Ninan, 1994). Some individuals with Trichotillomania also have urges to pull other people’s hair or may pull hairs from pets, dolls, carpets, and sweaters (APA, 2000).

Individuals with Trichotillomania often experience feelings of relief and comfort when pulling out their hair. Some individuals experience an “itchlike” sensation in the scalp that is only relieved by pulling their hair. Pain from pulling their hair is not usually reported by individuals with Trichotillomania (APA, , 2000). Mouthing of the hair pulled and trichophagia (eating hairs) may occur (Rothbaum & Ninan, 1994). Trichophagia may cause hairballs to develop leading to abdominal pain, anemia, hematemeses, nausea, and bowel obstruction. Trichotillomania onset is usually in young adulthood. Females are diagnosed much more frequently than males. However, men could be underdiagnosed due to hair loss in men being seen as a normal occurrence. Many children go through periods where they pull out their hair, but the behavior must last for several months before the diagnosis is given. The diagnosis is not made if the hair pulling is related to another symptom such as delusions or hallucinations, Obsessive-Compulsive Disorder, Stereotypic Movement Disorder, or Factitious Disorder (APA, 2000).
Impulse-Control Disorder Not Otherwise Specified

This diagnosis is reserved for disorders of impulse control that do not meet the criteria for a specific Impulse-Control Disorder or for another mental disorder with features involving impulse control; e.g., Substance Dependence or Paraphilia (APA, 2000).

References


Eating Disorders

Allison Y. Baise

Mental health and mental illness are best understood as states or points along a continuum that range from good to poor. This “spectrum” concept suggests that mental illness and mental health are not separate entities but rather are part of an ever changing process that are experienced throughout the life cycle. Like other diagnostic entities, Eating Disorders should be viewed as falling along such a spectrum. Following this line of thinking, the spectrum along which Eating Disorders exist consists of any concern about weight, calories, diet, or figure that can be viewed as common to abnormal distortions of body image, frequent binge and purge cycles, or when the pursuit of thinness becomes so entrenched that severe restriction of food occurs. Because European and North American cultures are obsessed with size, weight, and body image, this preoccupation is perceived as normal. However, at some point, the obsession becomes pathological. Eating Disorders are now recognized as major medical and psychological problems, affecting millions of women in the United States and Europe. The sociocultural emphasis on thinness is generally credited as a major determinant of the apparent increased incidence of Eating Disorders, especially among young women. The most common Eating Disorders found among adolescents and adults are Anorexia Nervosa and Bulimia Nervosa. Additional Eating Disorders, not discussed, include Pica (the eating of non-nutritive substances), Rumination Disorder (regurgitation and re-chewing of food), and Obesity. Obesity is included in the International Classification of Diseases as a general medical condition but does not appear in the Diagnostic and Statistical Manual Disorders (APA, 2000) because
Anorexia Nervosa
An individual who receives the diagnosis of Anorexia Nervosa can best be described as refusing to maintain a normal body weight for age and height, is extremely afraid of gaining weight, and has a significantly distorted body image. Weight loss is most commonly achieved by reduction and restriction of food intake among persons with this disorder and results in amenorrhea. In addition, these individuals may resort to purging through induced vomiting or the use of laxatives and/or diuretics. Persons with Anorexia Nervosa also may become immersed in extensive exercise to shed pounds. Two subtypes of Anorexia Nervosa have been established by the DSM-IV-TR. The “Restricting Type” is specified if the person has not regularly engaged in binge-eating or purging behavior during the current episode of Anorexia Nervosa. A second subtype, “Binge-Eating/Purging Type,” is noted when the person has regularly engaged in binge-eating or purging behavior during the current episode of Anorexia Nervosa. Individuals with Anorexia Nervosa have an extreme fear of becoming fat or gaining weight such that they are never completely satisfied with their weight loss, even though they may become emaciated. Their body image is so distorted that they ignore their body’s signals for sustenance and may become severely malnourished. The average age at onset of Anorexia Nervosa is 17 years and rarely occurs in individuals over the age of 40. The course and outcome of this disorder vary among individuals: some recover after a single episode, others require hospitalization to restore weight, fluid, and electrolyte imbalances, and others die if no such intervention occurs.

Bulimia Nervosa
Unlike persons with Anorexia Nervosa who are obsessed with losing weight and are substantially underweight for their age and height, individuals with Bulimia Nervosa maintain a relatively normal weight and are obsessed with not gaining additional weight. These persons also engage in binge eating on a regular basis and employ inappropriate compensatory behaviors in an attempt to counter weight gain from the previous binge. A “binge” is defined as a period of unrestrained eating when a large amount; i.e., larger than most individuals would eat under similar circumstances of food is ingested. A binge is restricted to no more than two hours of time and would not include snacking on small amounts of food throughout the day. During a binge, a person with Bulimia Nervosa will usually consume high calories, easily ingested foods and does so in a secretive manner. Episodic binge eating is accompanied by an awareness of an abnormal eating pattern, fear of not being able to stop eating voluntarily, with depressed mood and self-deprecating thoughts following the binges. Another feature of Bulimia Nervosa is the use of inappropriate compensatory behaviors after a binge. The DSM-IV-TR stipulates two subtypes of Bulimia Nervosa. If the person regularly engages in self-induced vomiting or the misuse of laxatives, diuretics, or enemas during the current episode of Bulimia Nervosa, “Purging Type” would be noted. If the individual does not regularly engage in self-induced vomiting or the misuse of laxatives, diuretics, or enemas but uses other inappropriate compensatory behaviors such as fasting or excessive exercise during the current episode of Bulimia Nervosa, “Nonpurging Type” would be noted. It also is important to note that for a DSM-IV-TR diagnosis of Bulimia Nervosa to be given, the binge eating and inappropriate compensatory behaviors must occur, on average, at least twice a week for three months and not during episodes of Anorexia Nervosa. Like Anorexia Nervosa, Bulimia Nervosa usually begins in adolescence or early adulthood. The course may be intermittent, with binge eating alternating with periods of remission, or it may be chronic, with no definite periods of remission (APA, 2000).
Associated Disorders
Research has shown that Eating Disorders are often associated with other psychological problems, such as depression, various Personality Disorders, Anxiety Disorders, and Substance-Related Disorders. The DSM-IV-TR notes that between onethird and one-half of persons with Bulimia Nervosa also meet criteria for one or more personality disorders, most frequently Borderline Personality Disorder. Persons with Anorexia Nervosa, according to the DSM-IV-TR, may exhibit other obsessive and compulsive symptoms, and hence, receive an additional diagnosis of Obsessive-Compulsive disorder. Thus, from a clinician’s perspective, it is imperative that these secondary problems be evaluated and incorporated into a comprehensive treatment plan.

Atypical Eating Disorders
In diagnosing Eating Disorders, clinicians often can apply a DSM-IV-TR diagnosis with ease. However, there are times when individuals may present with eating disordered characteristics that are less severe than those required for a diagnosis of Anorexia Nervosa or Bulimia Nervosa. Differentiating Eating Disorders from other disorders that involve atypical eating patterns or obsession with weight control can be difficult. Other diagnoses must be considered to rule-out other psychological or medical conditions. Fortunately, the DSM-IV-TR contains a Not Otherwise Specified (NOS) category in each of its diagnostic classes. Such a diagnosis would be warranted if the clinical features of the disorder do not meet all of the criteria for any of the disorders in a particular class, yet enough information is available to indicate a specific class of disorders. In the case of an individual presenting symptoms of an Eating Disorder that cannot be classified as Anorexia Nervosa or Bulimia Nervosa, the individual may receive a diagnosis of Eating Disorder NOS. Eating Disorder NOS may include, but is not limited to the following:

(a) a female who meets all of the criteria for Anorexia Nervosa but has regular menses,
(b) criteria for Anorexia Nervosa are met but the individual’s current weight is in the normal range,
(c) criteria for Bulimia Nervosa are met but bingeing and inappropriate compensatory behavior patterns occur less than twice a week and for a period less than three months,
(d) inappropriate compensatory behavior by a person of normal body weight that does not follow a binge (e.g., self-induced vomiting after consumption of a candy bar),
(e) a pattern of chewing large amounts of food and spitting it out instead of swallowing, and
(f) repeated episodes of binge eating not followed by inappropriate compensatory behavior (APA, 2000).

Continuum of Prognosis
Although research shows that persons with Eating Disorders have a 60-70% recovery rate after five years, there is a proportion of these individuals who do not fully recover. With third-party payers dictating duration of treatment, the short-term treatment model proposed is insufficient for many individuals with Eating Disorders. Short-term therapies such as psychoeducational, cognitive, behavioral, and psychopharmacological assist in helping only a reported 40 -50% percent of all diagnosed cases. It is important for counselors to act as advocates for these clients. Logically, if short-term therapy has not proven to be successful for about one half of individuals with Eating Disorders, mental health counselors must push third-party payers toward allowing longer durations of treatment.

References


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Sleep Disorders

Joseph P. Jordan

One thing taken for granted is the ability to fall asleep. It is a function of the body to provide a time to rest body and mind, and despite all attempts to deny the body sleep, we eventually have to sleep. People who have gone without sleep for a week or more, usually as a publicity stunt or as part of a study have reported dizziness, impaired concentration, irritability, hand tremors, and hallucinations (Dement, 1972, Johnson, 1969). Prolonged sleep deprivation in animals generally produces severe consequences, including death (Rechtschaffen, Gilliland, Bergmann, & Winter, 1983). When this normal body function somehow goes awry, a person can experience significant distress accompanied by extreme debilitation. When there is a problem with a person’s ability to achieve, maintain, or exit from sleep, then they may be diagnosed with a sleep disorder. Sleep disorders are classified in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition – Text Revision, DSM-IV-TR (American Psychiatric Association [APA], 2000), and are quite varied in nature. An understanding of these various ailments will help a counselor correctly diagnose sleep disorders, while allowing for differentiation between sleep disorders, temporary sleep difficulty, and other mental illnesses.

Sleep Disorders did not appear in the DSM I or DSM-II. They were listed only as an appendix in the DSM-III and appeared for the first time as a distinct set of diagnoses in the DSM-III-R. The sleep disorders are organized into three major sections, according to presumed etiology (APA, 2000). These include Primary Sleep Disorders,
Sleep Disorder Related to Another Mental Disorder, and Other Sleep Disorder, which is further subdivided into Sleep Disorder Related to a General Medical Condition and Substance Induced Sleep Disorder. Primary sleep disorders are further divided into Dyssomnias characterized by abnormalities in the amount, quality, and timing of sleep and Parasomnias characterized by abnormal behavior or physiological events occurring in association with sleep, specific sleep stages, or sleep-wake transitions (APA, 2000).

**Primary Sleep Disorders**

Primary sleep disorders are those disorders that are not attributable to other factors, such as another mental disorder, a general medical condition, or an imbibed substance that may affect sleep. As noted earlier, there are two categories of primary sleep disorders, dyssomnias and parasomnias.

**Dyssomnias:** These are disorders of sleep initiation, maintenance, or excessive sleepiness. They include Primary Insomnia, Primary Hypersomnia, Narcolepsy, Breathing Related Sleep Disorder, Circadian Rhythm Sleep Disorder, and Dyssomnia Not Otherwise Specified (NOS). Almost all the Dyssomnias result in a lower quality of sleep (the exception is Narcolepsy) and effect functioning of the individual. They are diagnosed when the person meets certain criteria, such as decreased level of functioning within an occupational environment, a social situation, or role responsibility. A brief description of each dyssomnia follows:

**Primary Insomnia:** Inability to achieve restful sleep, either through being unable to fall asleep or through waking up early and being unable to fall back to sleep. Individuals must experience this for at least a month to meet the criteria for this diagnosis.

**Primary Hypersomnia:** Excessive sleepiness such that there is an inability to function appropriately, lasting for at least one month, evidenced by prolonged sleep episodes or daytime sleep episodes that occur almost daily. This cannot be diagnosed if there is evidence of inadequate sleep.

**Narcolepsy:** Sudden irresistible attacks of restful sleep, accompanied by muscle paralysis (cataplexy) and often featuring intense dreamlike images before or after the attacks. Attacks usually occur two to six times a day.

**Breathing Related Sleep Disorder:** Sleep disruption during the nocturnal sleep phase associated with the existence of a physical abnormality, such as obstructive sleep apnea syndrome (APA, 2000).

**Circadian Rhythm Sleep Disorder** (Formerly Sleep-Wake Schedule Disorder): sleep disruption caused by environmental changes, rather than internal dysfunction. This diagnosis is associated with the inability to adapt to the demands of social interaction, perhaps due to the circadian rhythm being out of sync. There are four subtypes: delayed sleep phase; e.g., the “night owl”, jet-lag type (severity is proportional to time zones crossed), shift-work type (often due to rotating shifts), and unspecified type (when another pattern of sleep-wake disturbance is noted).

**Dyssomnia Not Otherwise Specified:** Insomnias, hypersomnias, or circadian rhythm disturbances that do not meet criteria for any specific Dyssomnias. Examples include insomnia due to environmental conditions (noise, light, interruptions), sleepiness due to sleep deprivation, restless legs syndrome, etc. (APA, 2000).

**Parasomnias:** These are disorders of abnormal behavior or physiological events occurring during sleep, specific sleep stages, or sleep-wake transitions. It is a lack of control of physiological systems, particularly the
autonomic nervous system, motor system, or cognitive processes. Parasomnias occur throughout the night, and often accompany specific sleep stages. Parasomnias include Nightmare Disorder, Sleep Terror Disorder, Sleepwalking Disorder, and Parasomnia Not Otherwise Specified (NOS). A brief description of each follows:

_Nightmare Disorder:_ Repeated occurrence of dreams that produce intense fear or anxiety due to the threatening nature of the sequences contained within the dream, producing awakening and full alertness upon awakening.

_Sleep Terror Disorder:_ Also called “night terror,” this sleep disorder is manifested by abrupt awakenings from sleep, usually accompanied by a panicky scream or cry, usually occurring during the first third and the last ten minutes of sleep. Individuals cannot be comforted; they exhibit fear and have little memory of the event upon awakening.

_Sleepwalking Disorder:_ Repeated episodes of complex motor behavior, including rising from bed and walking, usually during the first third of the night. Individuals are unresponsive to efforts at communication, and have limited recall of the occurrence. There is often a brief period of confusion or difficulty orienting, followed by full recovery of cognitive functions.

_Parasomnia Not Otherwise Specified:_ For disturbances that are characterized by abnormal behavior or physiological events during sleep or sleep-wake transition that do not meet criteria for established Parasomnias. Examples include: REM sleep behavior disorder (motor activity during REM sleep), sleep paralysis (inability to perform voluntary movement during transition from sleep to wakefulness or before falling asleep), and other parasomnias undetectable due to substance use or a general medical condition.

_Sleep Disorders Related to Another Mental Disorder_
This class of sleep disorder is related either temporally or causally to another mental disorder, such as depressive disorders, bipolar disorders, or anxiety disorders. Disturbed sleep is one of the principle symptoms of endogenous depression; furthermore, changes in sleep often presage clinical improvement or relapse (Wehr, Gillin, & Goodwin, 1983). As with other sleep disorders, the hypersomnia or insomnia must

(a) have lasted at least one month,
(b) there must be significant impairment in social, occupational, or other important role functioning,
(c) it cannot be accounted for by another sleep disorder, and
(d) there is no presence of inadequate sleep.

Also, there cannot be a medical condition or substance use that may account for the disorder. Sleep disturbances are common features of mental disorders. A diagnosis of Insomnia Related to Another Mental Disorder or Hypersomnia Related to Another Mental Disorder is only made when enough impairment exists to warrant clinical attention. Clinicians must make sure that this is a predominant complaint and then be able to use specific questioning and interviewing techniques to determine if a diagnosis is in order. Insomnia Related to Another Mental Disorder is the most frequent diagnosis at sleep disorder centers constituting 35% - 50% of diagnoses (DSM-IV, 1994). Hypersomnia Related to Another Mental Disorder is much less frequent, diagnosed about 5% of the time. In diagnosing either Insomnia related to Another Mental Disorder or Hypersomnia Related to Another Mental Disorder, one must be able to correctly identify the mental disorder causing the sleep disorder. An example would be Insomnia Related to Bipolar I Disorder, Single Manic Episode, Severe (APA, 2000).
Other Sleep Disorders
The primary feature of Sleep Disorder Due to a General Medical Condition is a disturbance in sleep significant enough to require clinical attention and which can be traced to a general medical condition. It should be noted for convenience’s sake, Narcolepsy and Sleep-Related Breathing Disorder are not included in this category. The clinician must first determine the presence of the general medical condition and then provide evidence (history, examination, or laboratory findings) that confirm that the sleep disorder is related to the condition. This sleep disorder has four specific subtypes, which are Insomnia Type, Hypersomnia Type, Parasomnia Type, and Mixed Type. The clinician assigns these subtypes according to which of the symptoms associated with the analogous Primary Sleep Disorder that the individual may exhibit. Note: The diagnosis of Sleep Disorder Due to a General Medical Condition, Mixed Type is used when more than one disorder is present and no one condition predominates. Also, you must include the name of the general medical condition on Axis III (e.g., Sleep Disorder Due to Chronic Obstructive Pulmonary Disease, Insomnia Type) (APA, 2000).

Substance-Induced Sleep Disorder
This sleep disorder is diagnosed when there is significant disturbance of sleep to warrant clinical attention, and there is evidence from history, physical examination, or laboratory findings that the disturbance is due to the direct physiological effects of a substance (a drug of abuse, a medication, or toxic exposure). The disorder may not be accounted for by another mental disorder that is not substance-induced, and the diagnosis cannot be made if it is observed during the course of delirium. There must be significant impairment in social, occupational, or role function responsibilities, and this diagnosis should only be made in place of Substance Withdrawal or Substance Intoxication if there is symptomology in excess of what is normally associated with Intoxication or Withdrawal syndrome. Mental Health Counselors must be careful when determining if this disorder is a result of substance use alone, or if the person began self-medicating to treat an already existing or developing sleep disorder and summarily developed a Substance-Induced Sleep Disorder. One of four subtypes may be noted: Insomnia or Hypersomnia being most prevalent, Parasomnia being less prevalent, and Mixed being used when no one subtype dominates but two or more are currently present. There are two specifiers: With Onset During Intoxication (criteria met during the intoxication phase), and With Onset During Withdrawal (criteria are met during withdrawal phase). If there is more than one substance judged to have a role in the development of the sleep disorder, both or all are mentioned. The name of the substance is mentioned at the beginning of the diagnosis (Cocaine Induced Sleep Disorder, Insomnia Type, With Onset During Intoxication) to lend clarity to the diagnosis. If the causal substance is unknown, a diagnosis of Unknown Substance-Induced Sleep Disorder may be given. Common substances that may produce this sleep disorder include: alcohol, caffeine, amphetamines and related stimulants, cocaine, opioids, sedatives, hypnotics, anxiolytics, and certain drugs prescribed for the control of hypertension.

Conclusion
The ability to obtain a good night’s sleep is taken for granted by most of the population. Oftentimes, part of the treatment for mental disorders includes rest and relaxation. Sleep disorders rob people of the ability to obtain this needed rest, and can greatly complicate treatment of these disorders. Sleep disorders demand attention, both on their own and when observed in conjunction with other therapeutic issues. Awareness of the possibility of a sleep disorder and correct diagnosis of such a disorder better serves the clients of mental health counselors.
Personality Disorders in the DSM-IV-TR

Kyra Martin-Houser & Jane G. Robertson

Personality Disorders are pervasive patterns of behavior that are developed in adolescence or early adulthood, independent of the individual’s cultural orientation, and lead to impaired functioning. The Personality Disorders in the DSM-IV-TR are categorized into three clusters based upon functional similarities. Cluster A includes the Paranoid, Schizoid, and Schizotypal Personality Disorders and describes individuals who exhibit eccentric traits. Cluster B includes the Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders. Individuals with Cluster B disorders are characteristically emotional and dramatic. Cluster C includes the Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders. Individuals with these disorders have an anxious or fearful presentation. It is important to note that many individuals exhibit traits from several different personality disorders concurrently; thus, a diagnosis of Personality Disorder Not Otherwise Specified (NOS) may be appropriate (APA, 2000).

A diagnosis of a Personality Disorder should be given when an individual exhibits traits and behaviors in early adulthood which are enduring, inflexible, maladaptive, cause significant impairment in functioning, and do not occur exclusively during an episode of an Axis I disorder. Personality Disorders are coded on Axis II and great care should be taken in using these diagnoses during an episode of a Mood Disorder or an Anxiety Disorder because some defining characteristics of these disorders may mimic the symptoms of a Personality Disorder. Furthermore, a diagnosis of Personality Disorder should not be given to an individual who is experiencing
substance intoxication, withdrawal, or dependency since an accurate assessment of the individual’s true
behavior may not be possible. When physiological effects of a general medical condition cause a persistent
change in an individual’s personality, a diagnosis of Personality Change Due to a General Medical Condition
should be considered. It is important to note that the diagnostic categories for Personality Disorders should be
viewed as a guide rather than a rigid model; consequently, clients with the same Personality Disorder should not
be viewed in the same manner, and should not be given a particular diagnosis as a result (Millon, 1990).

The first disorder in Cluster A, Paranoid Personality Disorder, is described as a pervasive pattern of distrust
where the individual perceives the actions of others as malevolent. The individual with Paranoid Personality
Disorder has difficulty trusting others, believes others are deceptive, and exploitative, and has difficulties with
forgiveness. This disorder is more prevalent in males and accounts for approximately 0.5-2.5% of the general
population.

Schizoid Personality Disorder is characterized by a pattern of separateness from relationships and few
disclosures of feelings in social situations. Also, limited familial relationships, preference for solitary activities,
and flat affect may be present. This disorder occurs more frequently in males; however, consistent with the
defining characteristics of this disorder, an individual with Schizoid Personality Disorder is rarely found in
clinical settings.

The final disorder in Cluster A, Schizotypal Personality Disorder, is a rather stable pattern of discomfort and
difficulties with interpersonal relationships. Further, delusions, limited personal relationships, unusual beliefs
which influence behavior, and inappropriate affect may be present. This disorder accounts for approximately 3%
of the clinical population and occurs slightly more in males. The Cluster B diagnosis of Antisocial Personality
Disorder can only be given to an individual who is at least 18 years of age and who has exhibited evidence
of Conduct Disorder since age 15. Antisocial Personality Disorder is characterized by a disregard for societal
norms resulting in unlawful behaviors, aggressiveness, deceitfulness, impulsivity, irresponsibility, and lack of
remorse for any harm done to another person. Although this disorder may be under diagnosed in females, it
occurs more frequently in males and is more common among first-degree biological relatives.

Borderline Personality Disorder (Cluster B) is much more prevalent in females and accounts for approximately
2% of the general population. Common diagnostic features include intense relationships, abandonment issues,
suicidal and self-destructive behaviors, inappropriate anger, and mood instability. These maladaptive behaviors
are often reinforced because factors in the borderline individual’s environment inhibit the use of more effective
coping mechanisms (Linehan, 1994).

Histrionic Personality Disorder (Cluster B) is a pattern of attention seeking and inappropriate provocative
behavior. Individuals with this disorder are impressionable, overemphasize the intimacy of relationships, are
overly dramatic, attempt to draw attention to their physical appearance, and exhibit a shallow expression of
emotions. Additionally, the histrionic individual may behave according to extreme sexual stereotypes and may
appear as either overly masculine or feminine. An individual with Narcissistic Personality Disorder (Cluster B)
prevents an inflated sense of worth and requires the open admiration of those around them. These individuals are
often consumed with illusions of success, power, beauty, or love and they believe that they are “special.” This
belief is expressed through haughty and disdainful behaviors and a sense of entitlement. Other key traits are
being exploitative, lacking empathy, and extreme envy. Persons with Narcissistic Personality Disorder may have
increased difficulty in adjusting to the physical and occupational restrictions that accompany the aging process.
Individuals with *Avoidant Personality Disorder* (Cluster C) present a pervasive pattern of social inhibition, low self-esteem, and an increased sensitivity to criticism from others. There is variance in the degree that different cultures regard avoidance as appropriate, and this should be kept in mind when considering this diagnosis. Avoidant Personality Disorder is equally prevalent in both genders and it comprises about 10% of all outpatients in mental health clinics.

The essence of *Dependent Personality Disorder* (Cluster C) is an extreme need to be taken care of, which results in submissive and helpless behavior, and undue fears of separation. These individuals have trouble making everyday decisions, doing things on their own or alone, and they need others to take responsibility for most major areas of their lives. Another trait is great difficulty in expressing disagreement with others because of the fear of losing approval. A person with this disorder will go to great lengths to get and maintain the care of others, and will desperately seek another relationship as a source of nurturance when a close relationship has ended. One must be careful to consider the amount of dependence that is considered appropriate for each gender within a specific cultural setting; furthermore, one must use great caution in applying this diagnosis to children and adolescents for whom dependent behavior may be developmentally appropriate.

*Obsessive-Compulsive Personality Disorder* (Cluster C) is characterized by a rigid adherence to rules, lists, schedules, and interpersonal control. These individuals are consumed with perfectionism which can interfere with productivity because overly strict standards are not met. There is a pervasive rigidity and stubbornness which is exhibited in such behaviors as being a workaholic, being inflexible on moral and ethical matters, being miserly about possessions and money, and being unwilling to delegate work. Persons with Obsessive-Compulsive Personality Disorder usually show emotion in a very controlled manner, and are generally uncomfortable around those who are emotionally expressive. In empirical studies, this disorder appears to be twice as prevalent in men than in women.

The diagnosis of *Personality Disorder Not Otherwise Specified* (NOS) should be used when an individual presents the features of several different Personality Disorders, but does not meet the criteria for diagnosis for any one Personality Disorder. There are also specific personality disorders that are not included in the Classification section of the DSM-IV-TR, but are noted in the Other Conditions That May Be A Focus of Clinical Attention section. These Personality Disorders include Depressive Personality Disorder, and Passive-Aggressive Personality Disorder (APA, 2000).

The development of systematic treatment approaches for Personality Disorders has lagged behind because of a lack of models of these disorders that would help to guide their treatment (Clarkin, Marziali, & Munroe-Blum, 1992). Generally, marriage counseling or group therapy may be effective for Personality Disorders. Specifically, dialectical behavior therapy (Linehan, 1993) has been one of the only therapies to undergo rigorous empirical investigations with positive results. This therapy was developed specifically for patients with Borderline Personality Disorder, and although it has been used with other populations, the generalizability of this treatment has yet to be empirically verified. Theodore Millon (1988) has suggested that the best approach is Integrative Psychotherapy or a synthesis of many different theoretical and clinical approaches that are tailored to meet the specific personological needs of the client. The goals of this therapy are to balance deficiencies in the personality by using techniques that are best suited to modify their expression in the areas that are most problematic to the client (Millon, 1990).
Conditions That May Be a Focus of Clinical Attention:
The DSM-IV-TR V-Codes

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The DSM-IV-TR (American Psychiatric Association, 2000), V-codes are useful in providing a better explanation of a client’s symptomatology. They are often used in conjunction with another Axis I diagnosis. When used alone, it is important to note that V-codes are not typically insurance reimbursable. Diagnoses such as these, however, are vital for conveying information about a client to other professionals who may become involved in the case. In addition, use of these conditions is necessary when criteria for a formal Axis I or Axis II diagnosis are not met. Finally, the last reason for citing a V-code is if the individual has a problem that is related to a mental disorder, but the problem is significant enough to warrant independent clinical attention.

The subcategories under the heading of “Other Conditions That May Be a Focus of Clinical Attention” are: Psychological Factors Affecting Medical Conditions (psychosomatic symptoms), Medication-Induced
Movement Disorders, Relational Problems, Problems Related to Abuse or Neglect, and Additional Conditions That May Be a Focus of Clinical Attention. In this chapter, the latter three subcategories will be reviewed.

Relational Problems
It has been said that all problems are relationship problems. Although simplified, there is much truth in this statement. Many problems that clinicians face are issues with another individual. As with every classification within the DSM-IV-TR, the relational problems must cause clinically significant impairment in functioning.

It is important to note that there are many causes of relational problems between a parent and child, between partners, and between siblings. For example, if a parent remarries after a divorce and each of the partners has children, it is normal for siblings to perhaps engage in a power struggle. Therefore, it is important to remember that it is only if the problem is causing clinically significant impairment that it becomes a DSM-IV-TR diagnosis. It also is necessary to obtain all relevant information before making a diagnosis.

There are five V-codes under this particular title:

1. Relational Problem Related to a Mental Disorder or General Medical Condition, which includes a pattern of weakened interaction that is associated with a family member’s mental disorder or general medical condition.
2. Parent-Child Relational Problem, in which the clinical attention is focused on a pattern of interaction between parent and child that is analogous with clinically significant impairment in either individual or family functioning.
3. Partner-Relational Problems are characterized as difficulties of communication that are associated with clinically significant impairment in either individual or family functioning.
4. Sibling Relational Problems includes a focus of clinical attention on interactional patterns among siblings that are associated with clinically impaired functioning in individual or family functioning.
5. Relational Problem Not Otherwise Specified is the appropriate category when the focus of clinical attention is on relational problems that are not included by the above (i.e., a child’s difficulties with teachers) (APA, 2000).

Problems Related to Abuse or Neglect
Child abuse is defined by Public Law 93-247 as: A physical or mental injury, sexual abuse or exploitation, negligent treatment or maltreatment of a child under the age of 18; e.g., N.C. Gen. Stat., 1989. This section of the DSM-IV-TR focuses on abuse of individuals across all age groups and the neglect of children. In the future, neglect also may be a focus of clinical attention for the adult population (i.e., neglect of an elderly parent, neglect of an adult with mental retardation).

The V-codes are used here when the focus of clinical attention is on the perpetrator of the abuse or neglect. When the focus of attention is on the victim, the appropriate code is 995.5. There are five different V-codes listed under this heading.

1. Physical Abuse of a Child,
2. Sexual Abuse of a Child, and
3. Neglect of a Child
These are utilized when the victim is under the age of eighteen. When the victim of the abuse is an adult, the listings are

4. Physical Abuse of an Adult, and
5. Sexual Abuse of an Adult (APA, 2000).

**Additional Conditions That May Be a Focus of Clinical Attention**

*Noncompliance with Treatment* is used when the focus of the treatment is related to the client’s refusal to conform to necessary treatment. Reasons for refusal range from distress about the expense or side effects to interference with cultural and religious beliefs to the co-morbid presence of a mental disorder. If the problem is serious enough to require separate attention during the treatment process, then this condition should be noted in the client’s diagnosis.

When an external incentive is the primary motive for feigning illness, then the diagnosis of *Malingering* must be applied. Malingering is often employed when the person wishes to avoid an unwanted requirement such as work, military duty, or criminal prosecution. This condition should be suspected if the client is referred by an attorney, if objective findings do not match the client’s description of the problem, and if the client refuses to cooperate with treatment. Malingering differs from both Factitious Disorder and Somatoform Disorders because it requires intentional reproduction of symptomatology and receipt of external incentives.

Two V-codes exist to describe antisocial behaviors that are not the direct result of a mental disorder. Adult Antisocial Behavior, or Child or Adolescent Antisocial Behavior is assigned when the individual exhibits behaviors not severe enough to warrant the diagnosis of Antisocial Personality Disorder, Conduct Disorder, or an Impulse-Control Disorder. In adults, this may describe the actions of some professional thieves or illegal drug dealers. In children and adolescents, the behavior may be displayed through isolated non-patterned antisocial acts.

When a client demonstrates problems in cognitive functioning that are not severe enough to warrant the diagnosis of a mental disorder, two other possibilities exist. When a person’s IQ is in the 71-84 range, the category of Borderline Intellectual Functioning may be exercised. This Axis II diagnosis may be difficult to determine when a severe mental disorder exists as well. Although not a V-code, Age-Related Cognitive Decline is found in this section as well. It is applied when a person’s intellectual abilities are affected as a direct result of the aging process but do not exceed the normal limits when given the client’s age. Neurological difficulties and specific mental disorders must first be ruled out prior to utilizing these diagnoses.

The condition of *Bereavement* can be given when clinical attention is focused on the reaction to a death of a loved one. Although the symptoms of Bereavement may mimic that of a Major Depressive Episode, the latter diagnosis is withheld until the individual exhibits the symptomatology for two months after the death. In addition, if hallucinations, feelings of worthlessness, marked dysfunction, or excessive guilt exist, then Bereavement should be replaced by a diagnosis such as Major Depression or Acute Stress Disorder.

The remaining six conditions refer to problems in various aspects of an individual’s life. All are used when the focus of clinical attention is not due to a mental disorder, or a mental disorder does exist; when the condition is severe enough to require independent attention. The code for Academic Problem is selected when the individual presents with a pervasive pattern of underachievement or difficulties in school without the symptomatology for a Learning or Communication Disorder. In addition, Mental Retardation should be ruled out before this code
is assigned. When an individual presents with problems solely involving their job or career in the absence of a mental disorder, then the condition of Occupational Problem is given. Examples of these may include job dissatisfaction or problems with career decision-making.

Identity Problem is not specifically a V-code, but it is included in this section of the DSM-IV-TR. When a client presents with an issue concerning goals, friendship, sexual orientation, morals, or loyalties to people, then this would be the correct condition to assign. These issues must exist without the presence of a mental disorder before the counselor can determine this condition. After a person converts to a new religion or begins to question faith in their own religion, a Religious or Spiritual Problem may occur. While these may or may not be related to a specific religion, the issues faced must involve faith in order to warrant this diagnosis. The condition of Acculturation Problem occurs when a person has difficulties adjusting to a culture different than the original one. This may occur when a person emigrates to a new country or when someone moves to a different part of the same country; e.g., from northern U.S. to Southern U.S. Finally, a Phase of Life Problem is assigned when the individual’s issues revolve around a particular time of life. This may be a developmental phase or a change resulting from marriage, divorce, schooling, career, or parenthood. The primary factor for this diagnosis is the direct relationship between the symptoms and the change in life phase (APA, 2000).

Conclusion
A variety of theoretical options exist for effective counseling of persons with V-codes. Counselors may choose to focus on the affect, behavior, or cognition of the client. In most cases, the counselor should identify the basic needs and future goals of the client. Bereavement and abuse are extremely different than borderline intellectual functioning and occupational problems, but all are conditions that may be a focus of clinical attention. It is important not to assume that clients are any less distressed because they present with these issues; they are often primary reasons for why someone seeks counseling. Although V-codes are not “true mental disorders” and may not be covered by a client’s insurance or managed care plan, they may be the most appropriate diagnosis for the presenting symptomatology.

References


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