

Dsm iv diagnosis

[Psychology](#), [Psychotherapy](#)



ABSTRACT

This paper aims to present relevant disorders that are “ socially” significant because they are present in all socioeconomic levels and has an alarming increasing prevalence worldwide. I chose to focus on eating and gender identity disorders, creating a story about an adolescent male. This is so because I have several friends who have these disorders. The purpose of the paper is to show how they evolve to their present selves.

Mr. X is an 18 year old, Filipino, male, stowaway, who was brought to the emergency room by the police. He was taken into custody after a drug raid in Malate, Manila where he was taking marijuana. Mr. X is an extremely thin individual, pale, dressed simply in a t-shirt and jeans. He has a pronounced feminine voice inflection. His feminine gestures were exaggerations of an effeminate, swishy gait and arm movements. He sits with his legs crossed very effeminately and his arms folded. The interview session that followed was marked by temporary unawareness of surroundings and visual hallucinations lasting for 2-3 hours. He was admitted and put on sedation.

Next day Mr. X was much more approachable. He began to talk about his life. His role model was his maternal grandmother who used to “ dress him up and raise him as a girl” died before his 5th birthday with alcoholism. His father, in his adolescent years also drank and dabbled in drugs and he died in a work accident. His mother, a very abusive woman, had four marriages in and Mr. X had 5 half-brothers and 2 half-sisters. After her 4th failed marriage, Mr. X’s mother stopped working and began drinking

and smoking cannabis. At this time, he was 7 years old, and had to stop schooling to take care of his younger siblings. His only solace back then was his friends, who, like him, were very preoccupied with “ thoughts of boys” and their weight. When he was 14 years old he started inducing vomiting and thereon, had up to 10 episodes of bingeing and vomiting weekly, and had a stable pattern of persistent food restriction. To lose more weight, he also experimented with cannabis (i. e., he swears that his mother never eats because of it) and also started smoking.

By the time he was 16, he was using cannabis several times a day and smokes 2 packs of cigarettes/day. Sessions of inhalation might last a few seconds, or up to half an hour. They ended when the craving and euphoria ended. He had often tried to stop or cut down but ended with failure. At this time, he ran away from home.

He stayed in a friend’s house and started working as a beautician. He tried to decrease his marijuana intake for a number of reasons: he wanted to take care of his younger brothers and sisters, and felt that he was at a point in his life where he needed to become more serious-minded. But his friends, continue to influence him, “ It was a vicious cycle.”

The physical exam had determined that his sexual status was normal prepubertal male with a normal 46XY male karyotype. Physical and laboratory examinations showed extensive dental caries, malnutrition, ulcer, and iron deficiency anemia. Current GAF is 40 and past GAF is 70.

Let us start from Axis I. Axis I pertains to Clinical Disorders, most V Codes, and conditions that need Clinical attention. In this case, the patient

has Bulimia Nervosa, Gender Identity disorder, adolescent, cannabis dependent and nicotine dependent. In this case we can say that his being bulimic is a result of his gender identity. This condition is also the cause why he has dental caries (Gastric acids, as a result of induced vomiting, reach the oral cavity and may cause a deterioration of tooth enamel) iron deficiency anemia, and malnutrition (food that he takes does not get digested and thus nutrients are not absorbed in the body). Treatment of this disorder includes psychotherapy with or without the aid of pharmacologic intervention. Halgin & Whitbourne (1994) states that Cognitive-behavioral therapy principally involves a systematic series of interventions aimed at addressing the cognitive aspects of bulimia nervosa, such as the preoccupation with body, weight and food, perfectionism, dichotomous thinking and low self-esteem. This therapy also addresses the behavioral components of the illness, such as disturbed eating habits, binge eating, purging, and dieting. Patients typically record their food intake and feelings. They then receive extensive feedback concerning their meal plan, symptom triggers, caloric intake and nutritional balance. Patients are also instructed in cognitive methods for challenging rigid thought patterns, methods for improving self-esteem, assertiveness training, and the identification and appropriate expression of feelings. If there is a need for pharmacologic intervention, the physician may use tricyclic antidepressants, monoamine oxidase inhibitors, and selective serotonin reuptake inhibitors. By treating this problem, we are also modifying his eating behavior thus slowly reversing the malnutrition, and iron deficiency anemia. The ulcer can be healed through pharmacologic intervention.

With regards to the gender identity disorder, In typical cases, the treatment is conservative because gender identity development can rapidly and unexpectedly evolve. Teenagers, like Mr. X should be provided psychotherapeutic support, educated about gender options, and encouraged to pay attention to other aspects of their social, intellectual, vocational, and interpersonal development.

For substance dependence (cannabis and nicotine), Astolfi, Leonard & Morris (1998) had stated that dependence does not require treatment because the withdrawal syndrome is so mild and most users can cease their use without assistance. However, if all else fails, psychotherapy is needed and involves brief advice, assisted cessation of cannabis use together with education about its acute and chronic effects, assistance with withdrawal symptoms and being involved in self help groups. We should also note that much of this therapy depends on Mr. X's control and resolve. Second level of diagnosis is the Axis II. Axis II, V71. 09 means that there is no mental Retardation nor personality disorders. Axis III diagnoses: Malnutrition; vitamin deficiencies; ulcer, has already been discussed concomitant with bulimia.

Axis IV: School difficulties, ran away from home. We must consider that he had lost his father at an early age, had an abusive mother, and several siblings whom he took care of at an early age (which is the reason why he left school). These could have led to his " running away from home." Metaphorically we could say that this person is running away from his responsibilities. Again, through psychotherapy, Mr. X could be persuaded to go back to school and home after dealing with his drug dependence and eating disorder. Axis V: GAF-40 current/ GAF-70 past. Halgin & Whitbourne

(1994) defines GAF as Global Assessment of Functioning Scale. Having a GAF of 70 means that there are some mild symptoms or some difficulty in social, occupational, or school functioning, but generally functioning pretty well and has some meaningful interpersonal relationships. A GAF of 40 means that there is some impairment in reality testing or communication or major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood. From here we can conclude that Mr. X's mental state is deteriorating and needs to be treated but only as an outpatient.

In conclusion, I can say that Mr. X is a victim of circumstances like all patients with mental disorders. However, through continuous follow-up and psychotherapy there might still be a chance for him to bring back something he lost. Recovering fragments of himself might be helpful so that he can truly identify who he is and what he must do to overcome the obstacles that life will bring to his path.

References :

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