2

Diagnosis

Understanding and Using the DSM-5

Introducing Chapter 2: Reader Highlights and Learning Goals

In comparison with everyday natural helpers, and in comparison with other professional service providers in the human services and related fields, being able to form diagnostic impressions using the *Diagnostic and Statistical Manual, Fifth Edition* (*DSM-5;* American Psychiatric Association [APA], 2013) is an essential skill in today's mental health workplace. Practitioners, including professional counselors and psychotherapists, clinical social workers and psychologists, and psychiatrists are expected to be proficient using the *DSM-5* classification system. Depending on the type of practitioner and setting, these professionals are ethically obligated and sometimes legally required to provide responsible diagnoses that set the stage for counseling and treatment (Robinson, 2003; Rosenberg & Kosslyn, 2011; Seligman, 1996). Even counseling professionals who do not actively make diagnoses on a daily basis—such as school counselors in typical school systems—must become conversant in the diagnostic language of the *DSM-5* in order to be effective in the multidisciplinary settings in which they work. As we indicated in the previous chapter, effective assessment and diagnosis leads to case conceptualization, subsequent treatment planning, and, in turn, the important work that occurs when we sit down with our clients with the goal of bringing about positive changes in their lives.

At the same time, learning to manage the *DSM-5* diagnostic classification system can seem especially daunting for new counselors: After all, the text comprises more than 900 pages, contains hundreds of diagnoses, and weighs almost 4 pounds! Correspondingly,

(Continued)

(Continued)

Chapter 4 provides the information you will need to start the learning process. In this chapter, first we introduce mental health diagnosis as it is practiced today and define *diagnosable mental disorder.* We include an explanation of the term *criterion-referenced.* We discuss the purposes and benefits, as well as the limits, of making a diagnosis, and we identify some of the most common reservations counseling professionals have raised about *DSM-5* classifications.

Next, we present the *DSM-5*'s organizational structure and explain how to successfully use the manual. Then, one by one, we take a more detailed look at each of the diagnostic criteria chapters as well as psychosocial and other factors to consider when formulating a diagnosis. Finally, we pull it all together, demonstrate how to make a start-to-finish diagnosis, and summarize what we have covered. Throughout the chapter, we offer learning activities and professional and clinical snapshots and refer to our 10 clinical cases in order to illustrate our main points about understanding and using the *DSM-5.*

At the end of the chapter, you should be able to:

- Discuss the role of diagnosis in today's professional counseling settings
- Describe the use of the *DSM-5* classification system in contemporary mental health diagnosis
- Discuss the purposes, benefits, and limited role of a diagnosis
- Identify and discuss the most important counselor reservations about diagnosis using the *DSM-5*
- Define "diagnosable psychological disorder" and "criterion-referenced"
- Demonstrate how to read and understand a fully prepared *DSM-5* diagnosis
- Demonstrate the ability to fully prepare start-to-finish diagnostic impressions using the *DSM-5* text in learning, skill-building, and supervised training contexts that are within the ethical domain of your competency and experience levels

Diagnosis in the Professional Counseling Context: *DSM-5* Classification System

The earliest European and North American mental health diagnostic systems referred to various forms of "madness" (Rosenberg & Kosslyn, 2011), and the earliest system of diagnosis formally used in the United States included only two classifications: "idiocy" and "lunacy" (APA, 2000a). Today, nearly all mental health professionals in the United States rely on the *DSM-5* as the primary system for making clinical diagnoses, and the system is used increasingly internationally. The *DSM* was

introduced in 1952 by the American Psychiatric Association in collaboration with other mental health professional groups and underwent revisions in 1964 (*DSM-II*), 1980 (*DSM-III*), 1987 (*DSM-III-R*), 2000 (*DSM-IV-TR*), and 2013 (*DSM-5*). The system is intended to be an official nomenclature, applicable to a wide range of clinical settings and contexts. It is utilized by practitioners of many different clinical orientations. Specifically, it is used by "psychiatrists, other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors, and other health and mental health professionals"; and is used across settings that include "inpatient, outpatient [or outclient], partial hospital, consultation-liaison, clinic, private practice, and primary care, and with community populations [among others such as school settings and college and university health and mental health]" (APA, 2000a, p. xxiii).

The *DSM* provides a single, comprehensive system of diagnosis that covers all of the main concerns seen in infancy, childhood, and adolescence, young adulthood, middle adulthood, and later adulthood. This means, for example, that concerns ranging from Autistic Spectrum Disorder identified in childhood, through Anxiety and Depressive Disorders experienced in adulthood, to the later life onset of Neurocognitive Disorders due to Alzheimer's Disease, all appear together in the *DSM-5*'s pages. This is illustrated in our group of popular culture cases found in Chapter 5, where, for instance, Naruto presents the childhood and adolescent problems of Conduct Disorder and Attention-Deficit/Hyperactivity Disorder, Miss Celie presents an adult occurrence of Posttraumatic Stress Disorder, and Sophia presents late-life onset of Neurocognitive Disorder due to Alzheimer's Disease.

The *DSM-5* is designed to cover client concerns in all four domains of client experience: mood, cognitions, behavior, and physiology. This means, for example, that concerns ranging from the mood problem of Major Depressive Disorder, to the thought problem of Delusional Disorder, to the behavioral problem of Kleptomania, to physiological problems such as Personality Change Due to a General Medical Condition, all appear within the system. In our case illustrations, you will find diagnoses centering on problems of mood, such as Edward Cullen's Persistent Depressive Disorder, on problems of thinking, and Eleanor Rigby's Intellectual Disability, and on problems with multiple facets, such as Maria's Acute Stress Disorder (ASD) and Jack McFarland's Attention-Deficit/Hyperactivity Disorder (ADHD).

The system was built to include immediate, short-term, and time-limited problems; more long-standing concerns that follow the client over a greater time period; and entrenched lifelong difficulties. This means, for example, that shorter-term Adjustment Disorders, more long-standing Substance Use Disorders, and the lifelong problems of Intellectual Disabilities and Personality Disorders all are contained within the *DSM*'s covers. Among our pop culture illustrations, for instance, Cleveland Brown's Alcohol Use Disorder, Belle's Social Anxiety Disorder, and Annie Wilkes's Bipolar I Disorder and Antisocial Personality Disorder each are covered.

Skill and Learning Exercise 2.1

Searching the *DSM-5*

Refer to Table 0.1 in this text. Working alone or with a partner, select three different popular culture characters that are of special interest to you. Find their case illustrations in Chapter 5 of our book and review the diagnostic impressions provided for each case. Now, using your own copy of the *DSM-5,* locate the page on which the primary diagnosis or diagnoses used to describe each of the three client's concerns is found. Answer the following: In which diagnostic classes or chapters do the diagnoses appear? Are they primarily diagnoses first made in childhood or in another phase of life? What are the time frames of the diagnoses (short-term, midrange, lifelong)? What are the main domains affected (feelings, thoughts, behavior, physiology)?

At the same time, although the *DSM-5* system is extensive, it also is designed to have limits and boundaries. Two important aspects of the system that are critical to our understanding of the *DSM* pertain to these limits and boundaries. They are the system's limited scope and its limited purpose.

Limited Scope: Definition of a Diagnosable Disorder

One common misperception about clinical diagnosis is that human experience is interpreted exclusively from a pathological point of view—that making a diagnosis leads to a pathological view of all of client concerns. In contrast to this misperception, the *DSM* is designed only to cover a small portion of human behavior or client experience, namely, conditions that meet the definition of *mental disorder,* also known as *psychological disorder* (we will use these two terms interchangeably in our text). According to the *DSM,* each diagnosable psychological disorder is a distinct pattern of thoughts, feelings, behaviors, or physiological symptoms that occurs in an individual and causes clinically significant personal distress, clinically significant impairment in one or more important areas of daily functioning, and/or significantly increased risk of harm (where risk of harm includes increased risk of pain or disability, loss of important freedoms, or death). Every *DSM-5* diagnosis includes a requirement that the client's experiences of distress, impaired functioning, or risk of harm are clinically significant—meaning that they are having a substantial negative effect on the person's life or the life of other people. In addition, these clinically significant symptoms must be unusual for their context—so that client experiences that are considered to be normally expectable reactions or culturally appropriate reactions to life events are not diagnosable as psychological disorders.

Given this limited definition of a diagnosable mental disorder, it follows that from a diagnostic standpoint, most human behavior or experience is considered functional, normal, and ordered, rather than dysfunctional, abnormal, or disordered. Further, there

are several specific types of client experiences that do not fall into the diagnosable category: These include normally expected, culturally appropriate, and life-phase appropriate or expectable experiences, and a few other types of nondiagnosable behavior.

Normally Expected, Culturally Appropriate, and Developmentally Appropriate Experiences. Client experiences that we believe are normally expectable responses and culturally appropriate reactions to life events or situations are not diagnosable as psychological disorders, even when they cause the person some distress or difficulty in daily living. For example, although grief following the death of a loved one may be a focus of counseling, a diagnosis of Major Depressive Disorder is not necessarily made even when the person experiences major depressive criteria like extreme sadness, loss of interest in everyday activities, insomnia, or poor concentration following the loss—providing the individual's reaction is considered to be a normally expected reaction and does not result in clinically significant impairment and the person does not also simultaneously meet the criteria for any of the major Depressive Disorders. In our text's popular culture caseload, for example, *West Side Story*'s Maria deals with Uncomplicated Bereavement.

Similarly, client behavior that we view as normally expectable phase-appropriate life-developmental experiences are not diagnosable as psychological disorders even though they cause distress or some difficulty with functioning. For instance, identity confusion in adolescence, which often is associated with distress about long-term life plans, relationships, and other decisions, is not diagnosable because it is considered a phase-appropriate developmental occurrence. Moderate changes in mood and functioning following a job lay-off, divorce, or retirement generally fall into this area as well.

Other Nondiagnosable Behavior. A few other conditions that are not diagnosable also should be noted. One is behavior that is considered by nonclinicians to be "deviant." The *DSM-5* does not address conflicts between an individual and society—such as political, religious, or sexual deviations from societal norms—unless these are the result of a diagnosable mental disorder. Likewise, because a client's negative experiences meet the legal or other nonclinical criteria for mental disorder or mental disability does not necessarily mean that the *DSM-5* criteria for a diagnosable psychological disorder has been met. In addition, there are psychological patterns that, although commonly used colloquially by nonprofessionals or even by professionals in their everyday conversations, are not diagnosable disorders because they do not appear in the classification system. For example, although *codependence* or *sex addiction* are commonly used terms in contemporary culture, they are not among the *DSM-5*'s diagnosable disorders.

Specific Purpose: Benefits of a Diagnosis

So far we have described the *DSM* diagnostic system's limited scope. It also was designed with a narrowly defined primary purpose: to assist clinicians in describing client concerns in order to communicate their view of the client's needs. In other words, diagnosis is a *descriptive tool.* It provides an agreed-upon language for characterizing a client's behavior, thoughts, feelings, and other aspects of distress, impairment, or risk.

It should help enhance agreement and improve the sharing of information among clinicians about the "client picture they are observing" (Neukrug & Schwitzer, 2006, p. 168). For example, when it is indicated by a previous counselor that our new client has been experiencing a Persistent Depressive Disorder, we are provided a great deal of information about the nature of the person's concerns. We know about the primary symptoms (low mood, loss of pleasure), associated symptoms (disruptions in sleep, appetite, concentration, etc.), minimum duration (at least 2 years), and severity of the distress, and that his or her mood problems are not due to substance use—all because we are familiar with the Persistent Depressive Disorder diagnosis. You will see a good example of this by reading the case notes and diagnostic impressions we present in Edward Cullen's case illustration in Chapter 5 of our text.

Importantly, *DSM-5* diagnoses are theory-neutral categorizations. Using the system to describe client experiences does not reflect any specific theoretical interpretation, disciplinary viewpoint, or causal inference. Instead, the system relies on the traditional medical/scientific approach of naming and organizing our client information in as objective a fashion as possible. The classification system divides client presentations into psychological disorders based on sets of criteria that are made up of observable features. In other words, *diagnoses in the* DSM-5 *are criterion-referenced, and our job is to match up client information with the sets of criteria the* DSM *provides for the various diagnoses.* Being objective and theory-neutral means that in and of themselves, diagnoses do not identify the etiology of the person's concerns, apply a theory to infer the causes or sustaining factors contributing to the situation, or offer a plan for intervention. For instance, the system does not use terms such as *neurosis* and *psychosis* that might indicate a psychoanalytic theoretical viewpoint, or terms such as *organic* and *inorganic* that might favor the biopsychiatric discipline. It is built with multidisciplinary users in mind.

However, the diagnoses *do* provide our starting point for moving on to the next steps of case conceptualization and treatment planning—where we apply our preferred theoretical viewpoint and counseling approach based on our own clinical decision making. The diagnosis provides our foundation for determining what the primary focus of counseling should be—for example, mood problems versus somatic symptoms, or solution focus versus life patterns such as a personality disorder. It helps us see what our treatment goals might be in the form of reducing or eliminating specific symptoms that are part of the diagnostic criteria set. It can help sort out the need for physiological interventions such as medical treatment; counseling interventions such individual or group interventions; and social interventions such as environmental adaptations in the community, school, or family. You will find a good illustration of this by reading the diagnostic impressions, case conceptualizations, and treatment plans we present in Naruto's case report in Chapter 5 of the text.

In addition, when the information is known, the *DSM* provides data for each diagnosis pertaining to primary diagnostic features and associated features supporting the diagnosis; prevalence, development, and course; risk and prognostic information; diagnostic considerations related to culture; subtypes and variations in client presentations; and how to differentiate among diagnoses that share a core of symptoms. It

Figure 2.1 The *DSM-5* in Context

Limited Scope	
What the Diagnostic System Covers	**What the Diagnosis System Does Not Cover**
Diagnosable psychological disorders defined as distinct patterns of thoughts, feelings, behaviors, and/or physiological symptoms that cause an individual clinically significant distress, impairment in functioning, and/or increased risk of harm Unusual for their situational and cultural context	Normally expectable reactions to life events or situations Culturally appropriate reactions to events or situations Life-phase-appropriate developmental patterns Conflicts between individual and society (Deviance) that are not due to another diagnosable disorder Patterns meeting legal or other professional definitions but not meeting *DSM-5* criteria Patterns described by colloquial definitions but not meeting any specific *DSM-5* criteria
Specific Purpose	
What the Diagnostic System Does	**What the Diagnostic System Does Not Do**
Provides an agreed-upon language for describing client concerns Enhances agreement and improves sharing of information about client situations Provides criterion-referenced, theory-neutral descriptions that assist with determination of primary focus of counseling Sets the stage for case conceptualization and treatment planning	Reflect any specific theoretical orientation Reflect any specific disciplinary viewpoint Infer etiology, sustaining factors, or other conceptual interpretations (other than indicating a medical cause) Determine the course of treatment

also provides research findings about predisposing factors, complications, and associated medical conditions when they are known. All of these elements are benefits of making the diagnosis.

Counselor Reservations About Diagnosis

Along with the benefits of diagnosis, important counselor reservations have been raised about the use of the *DSM-5* classification system. These reservations take the

form of apprehensions, cautions, critiques, and criticisms. We believe it is essential for effectively functioning clinicians to understand the reservations that sometimes are raised about the system along with its benefits. We already have addressed the misperception that the system views human behavior from an exclusively pathological viewpoint by discussing the *DSM-5*'s limit of scope. We also have addressed the misperception that the system determines the theoretical or disciplinary approach of the case conceptualization and treatment plan by discussing the *DSM-IV-TR*'s limit of purpose. Other counselor reservations have to do with social-cultural cautions as well as clinical criticisms. We want to describe a few of the reservations we hear most commonly expressed by students and new counselors and suggest the ways in which the *DSM* system attempts to address these issues. They include: potential for diagnostic bias, potential for stigmatization and labeling, underresponsiveness to social change, and overresponsiveness to payment pressures.

Potential for Diagnostic Bias. This counselor reservation relates to the potential for diagnostic bias, whereby clinicians might routinely overdiagnose, underdiagnose, or misdiagnose clients populating specific demographic groups, such as on the basis of ethnicity, gender, age, or socioeconomic status (Kunen, Niederhauser, Smith, Morris, & Marx, 2005; Meehl, 1960). As examples, researchers have reported that African American clients with mood disorders are likely to be misdiagnosed with schizophrenic disorders (Neighbors, Trierweiler, Ford, & Muroff, 2003; Trierweiler, Muroff, Jackson, Neighbors, & Munday, 2005), while Latina/o clients may tend to have their presenting concerns underdiagnosed by their counselors (LaBruzza & Mendez-Villarrubia, 1994; Schmaling & Hernandez, 2005).

The *DSM*'s authors attempt to address issues of gender and multiculturalism in several ways. Each diagnosis includes contextual information, when it is known, under the separate heading, "Culture-Related Diagnostic Issues" and "Gender-Related Diagnostic Issues." For instance, cultural variations in presenting complaints (somatic complaints as the main presenting problems in some cultures) are described along with the main criteria for the Major Depressive Disorder diagnosis. Age differences in the prominent features of many diagnoses are presented. For instance, variations in prominent Major Depression features include failure to gain expected weight among children and irritable mood among children and adolescents.

The *DSM*'s text also notes when the diagnosis of certain disorders among certain ethnic or age groups should raise questions for us (e.g., the *DSM* alerts us that an individual's cultural and socioeconomic background must be taken into consideration when making a diagnosis of Schizophrenia, especially when the client's cultural or socioeconomic background differs from the clinician's since ideas that appear to be delusional in one culture may be commonly believed among another population). Prevalence and patterns according to gender are indicated (e.g., lifetime patterns of Bipolar Disorder tend to differ among women and men, Major Depression appears to be diagnosed more commonly among women, and Obsessive-Compulsive Disorder tends to be diagnosed at an earlier age among males than females). Similarly, Histrionic Personality Disorder is more commonly diagnosed among women, while

Antisocial Personality Disorder is more often diagnosed among male clients. As counseling professionals, we must remain up to date on the growing clinical research literature about diagnostic bias and carefully read the information already available inside the *DSM*.

In Chapter 5 of our text, you will find that we considered these issues when forming diagnostic impressions for a variety of our cases; as illustrations, see our case notes and the diagnostic discussions for the cases of Maria and Miss Celie.

Potential for Stigmatization and Labeling. Another commonly expressed reservation among counselors is that diagnosis can become a stigmatizing label and therefore negatively affect how an individual views himself or herself, how others in the person's life react to him or her, or how the person accesses services and is responded to in his or her community (Eriksen & Kress, 2005; McAuliffe & Associates, 2008). To address this, counselors must be vigilant in correcting the common misperception that clinical diagnosis classifies or labels people; instead, the *DSM* really classifies the psychological disorders people are experiencing. To promote this, the *DSM-5* carefully uses phrases such as "an individual with Schizophrenia" and "an individual with Borderline Personality Disorder" rather than terms like "a schizophrenic" or "a Borderline" throughout the text (APA, 2013). As counseling professionals, we must use the same vigilance in our own communications about our clients and our diagnosis of their concerns. In our case illustrations, for example, we are careful to use this language when describing Cleveland Brown as a person with alcohol use concerns rather than as an alcoholic.

Underresponsiveness to Social Change. One more type of social-cultural reservation expressed by counseling professionals is that diagnosis is too unresponsive to social change. However, the authors of the *DSM* attempt to address this through the rigor of the revision process used to update the system. This constant updating process includes expert participation in literature reviews, data analyses and re-analyses, and field trials that employ careful thresholds for revision. The *DSM*'s historical management of the issue of homosexuality provides one example of the *DSM*'s responsiveness to changing societal and professional viewpoints. "Homosexuality" was classified as a mental disorder in the *DSM-II,* in keeping with professional standards of the time. Based on a change in expert consensus viewpoint, the disorder was replaced by "Sexual Orientation Disorder" in later printings of the *DSM-II* and then by "Egodystonic Homosexuality" in *DSM-III.* Both of these refer only to the situation in which an individual experiences clinically significant distress or impairment related to his or her thoughts, feelings, or behaviors pertaining to a lesbian, gay, bisexual, or transgendered (LGBT) sexual orientation. The change in viewpoint was based on the corrected finding that having a nonheterosexual sexual identity per se did not meet the criteria for a diagnosis. Subsequently this disorder was removed from *DSM-III-Revised* and did not appear at all in *DSM-IV.* Instead, "persistent and marked distress about sexual orientation" was provided in the *DSM-IV-TR* as one of several examples of a situation in which the diagnosis "Sexual Disorder Not Otherwise Specified"

(APA, 2000a, p. 582) might be used to best describe a client's primary concerns. With *DSM-5*, today's clinicians simply indicate there is no diagnosable mental disorder, but the designation "Sex Counseling" can be used when the client seeks professional support related to sexual orientation.

Overresponsiveness to Payment Pressures. Eriksen and Kress (2005) raised the concern that revisions, additions, and expansions to the *DSM* classification system sometimes may occur for reasons of payment pressure rather than clinical evidence or in response to professional advances. These authors suggested that because the mental health care industry requires that a client or patient be experiencing an accepted diagnosable mental disorder in order to be reimbursed by health insurance companies or other third-party payers, some of the additions, expansions, or criteria changes in the *DSM* may sometimes occur to help clinicians gain coverage rather than for reasons based on clinical evidence. According to this line of thinking, having more diagnoses, or more payment-sensitive diagnoses from which to choose, might increase the chances of receiving payment. Naturally, this raises critical issues about how we go about our professional practices. Although the question of payment pressures is not addressed directly in the *DSM-5*, it implies that diagnoses are designed for clinical and research purposes—rather than for other purposes. Competent and ethical practice requires counseling professionals to be cognizant that the purpose of a diagnostic system is to provide criteria as guidelines for making diagnoses, and [that] their use should be informed by clinical judgment" (APA, 2013, p. 21). In this text and in our case illustrations, we take the traditional, orthodox view that the diagnosis is for the purpose of accurate clinical description and should not be influenced by any nonclinical factors such as payment pressures. However, this counselor criticism is one that raises questions we believe you will need to carefully consider and understand, discuss in classes and with your colleagues, and raise with your experienced clinical supervisors as you make the transition to professional mental health practice.

Additional Thoughts. We now have introduced the *DSM-5* diagnostic system in the professional counseling context, explained what is meant by a diagnosable mental disorder and what is and is not covered by the system, discussed the purposes and benefits of making a diagnosis, and also reviewed some of the hesitations counselors express about diagnosis. Other reservations exist, of course, and many of these pertain to how the system itself operates, such as how the system handles medical illnesses that overlap psychological disorders, how the system handles commonly co-occurring problems such as coexisting depressive and anxiety disorders, the system's use of categorical criteria instead of criteria on a continuum, and so on. Later on, after you have developed a basic understanding of the *DSM* and basic diagnostic competencies, you may want to further investigate what the counseling research and professional literature have to say about these more advanced clinical criticisms. In the remaining portion of Chapter 2, we will turn to the nuts-and-bolts details of making a mental health diagnosis.

Skill and Learning Exercise 2.2

Analyzing Diagnostic Impressions

Refer to the case of *West Side Story*'s Maria appearing in Chapter 5 in this text. Read the intake summary, diagnostic impressions, and discussion of the diagnosis. You may also want to have your copy of the *DSM-5* available. Working alone or with a partner, consider the following:

So far in this chapter we have discussed the limited scope of a mental health diagnosis. You will see that a diagnosis of Acute Stress Disorder was decided upon to describe Maria's presentation. What characteristics of Maria's presenting concerns fall within the scope of the *DSM* and allow the diagnosis of a psychological disorder? What specific criteria were needed for the diagnosis of Acute Stress Disorder? Why do the characteristics of Maria's presenting concerns pertaining to her grief about the loss of her boyfriend fall outside the scope of a mental disorder diagnosis? How did the counselor indicate that grief and loss was not diagnosable but still would be the focus of counseling?

In this chapter, we discussed the specific descriptive purpose of a mental health diagnosis. What would it mean to you as a counselor to learn that Maria's symptoms were described by Acute Stress Disorder? What would you know about the types of symptoms she was experiencing? The types of life events she had experienced? About the time frame of her difficulties?

In this chapter, we discussed common counselor reservations about *DSM* diagnoses, including criticisms related to social-cultural considerations. How are they relevant to Maria's situation? How did Maria's intake counselor address these considerations?

Considering the benefits, limitations, and reservations about making a diagnosis, what do you believe are the advantages of having diagnostic impressions to guide the focus of counseling, case conceptualization, and treatment planning for our work with Maria? Do you believe there are disadvantages, and if so, what are they?

Finally, if you were Maria's intake counselor, how comfortable would you be with the diagnostic impressions found in this case illustration?

DSM-5 Diagnostic System

We said in Chapter 1 of our text that a *DSM-5* diagnosis is comprehensive. It attempts to provide a multidimensional description of a client's presentation or experience. We realize the responsibility for preparing a comprehensive diagnostic description can cause some confusion and even intimidation for students and clinicians who are new to diagnosis. Simply stated, several different pieces of information each contribute to a fully prepared diagnosis pertaining to a client with whom we are working. Having several pieces of information that describe different aspects of a client's or patient's presentation gives the counseling professional more room to fully characterize and

record what the person is experiencing. It allows us to describe our clients' experiences holistically, from several different points of view (Seligman, 2004)—including our view of their primary psychological concerns, related medical problems, life stressors, and overall levels of distress or functioning. For quick and convenient reference, instructions for using the system are provided to us right in the *DSM-5* text itself, on pages 19–24, so that as long as you have your copy of the *DSM* with you, you have the support you need as a beginning diagnostician. The main elements of a fully prepared diagnosis are summarized in Figure 2.2.

Clinical Disorders. Determining the mental disorder diagnoses that best describe the client's situation is seen as the most salient and important part of the diagnosis. It is through making the clinical diagnoses that we record all of the diagnosable psychological disorders of infancy, childhood, adolescence, and adulthood found throughout the entire *DSM-5*.

General Medical Conditions. Next, a comprehensive diagnosis gives us a place to list any medical problems and physical complaints that might be present in the client, especially when a medical or physical problem might be associated with the person's presenting psychological and counseling concerns.

Psychosocial and Environmental Problems. Following clinical disorders and health problems, the comprehensive diagnosis gives us an opportunity to record any psychosocial, social, relational, social-environmental, or other life stressors or pressures the client might be experiencing, especially when these stresses might be associated with the individual's presenting psychological concerns and counseling issues.

Assessment of Functioning. Finally, clinicians have the opportunity to provide an assessment of the client's level of distress, the impact of the symptoms he or she is experiencing, and how well the person is functioning in his or her various life roles. Such estimates typically are made using: specifier information found in the diagnostic criteria lists for the various disorders; severity indicators found in the diagnostic criteria lists for the various disorders; or a well-established relevant psychometric scale or another type

Figure 2.2 Comprehensive Diagnosis

Diagnoses of mental disorders	Principal diagnoses of clinical disorders Provisional diagnoses of clinical disorders Subtypes and specifiers
General medical conditions	Relevant medical and health problems
Psychosocial and environmental stressors	Relevant psychosocial and environmental stressors, problems, and contexts
Assessment of functioning	Clinical estimates of overall distress or functioning

of clinical estimate. The *DSM-5* itself presents a discussion of state-of-the-art assessment approaches on pages 733–748, which includes the "Clinician-Rated Dimensions of Psychosis Symptom Severity" for ranking the various positive and negative symptoms of psychotic disorders, including, foremost, Schizophrenia.

Skill and Learning Exercise 2.3

Understanding the *DSM-5* System

By now you have reviewed several of our case illustrations as you have completed our Skill and Learning Exercises and probably thumbed through others you found interesting. All of the cases provide examples of fully prepared diagnoses. At this point in your reading, refer to the case of Eleanor Rigby of the Beatles' *Revolver* album, appearing in Chapter 5. In this case, you will find an example of a complete diagnostic assessment, based on our own unique version of Eleanor Rigby's situation.

Examining Clinical Disorders, you will see we first recorded Eleanor Rigby's mood problem, Depressive Disorder Due to Hypothyroidism, according to *DSM* criteria. Next you will see we recorded the Intellectual Disability we described her as experiencing (read through the case for our unique take on Eleanor Rigby). Turning to General Medical Conditions, we then listed Hypothyroidism, since her thyroid condition is directly related to her low mood symptoms (read through the case illustration for more details). Following the mental disorder diagnoses and the general medical problem we thought were important, we went on to list the social and psychosocial problems that Eleanor Rigby confronts, which are related to living by herself since the loss of her husband and her need for some supervised support. Finally, concluding the diagnosis, you will see that Eleanor Rigby's counselor used a brief statement about her daily functioning to indicate the counselor's estimate of Eleanor Rigby's impairment and resilience.

Altogether, the diagnosis gives us a complete, holistic description of the client's current clinical situation. Now let us explore each of the elements of the diagnosis in more detail.

A Closer Look at the Clinical Disorders

The Clinical Disorders are the key components of the *DSM-5* diagnostic system. The 300 to 400 individual diagnoses contained in the *DSM-5* are used by counseling professionals in order to answer questions such as:

> "Does the client show signs and symptoms of any of the fifteen major classes of Axis I mental disorders?" "Are there conditions other than [diagnosable psychological disorders] that should be a focus of clinical attention?" and "Which is the principal diagnosis and reason for today's visit?" (LaBruzza & Mendez-Villarrubia, 1994, p. 86)

The *DSM-5* manual also provides the diagnostic wording that is used to indicate when the counselor is uncertain or undecided about a diagnosis, when the diagnosis will be deferred until later assessment, when no mental disorder diagnosis at all is indicated, and, alternatively, when multiple diagnoses are needed to characterize the client's presentation.

To become successful using the *DSM-5* mental disorder diagnoses, it is necessary to learn about two aspects of the *DSM* text: interchapter organization and intrachapter organization.

The Clinical Disorders: Interchapter Organization

The long list of diagnosable mental disorders is divided into 20 separate categories, called *classes of disorders.* Each class of disorders has its own chapter. Each of the diagnostic classes, or chapters, brings together various diagnosable psychological disorders that share common denominators—that is, each class or chapter of diagnoses in the *DSM* brings together various diagnoses that have natural similarities. For example, all of the diagnosable client problems related to substance use (e.g., alcohol dependence, cocaine abuse, withdrawal symptoms) are in the same class or chapter of disorders; all of the client concerns with depressed mood (major depression, persistent depressive disorder, etc.) are in the same class or chapter of disorders, and all of the clinically significant client difficulties reacting to life stressors and traumas (adjustment disorder, posttraumatic stress disorder, etc.) are in the same class or chapter.

A typical starting point for formulating a clinical diagnosis is to first decide which diagnostic class, or chapter, seems to hold the best tentative match with the client's presentation. For example, a typical starting point is to think about whether the person's symptoms—her thoughts, feelings, behaviors, or physiological signs—seem primarily suggestive of panic, a phobia, or social anxiety (found in the Anxiety Disorders), troubles with falling asleep, maintaining sleep, and being rested (found in the Sleep Disorders), or possibly sexual performance (found in the Sexual Dysfunctions). In other words, using the *criterion-referenced approach,* the counselor might first ask, "Can I narrow down the client's presenting concerns from all of the various diagnosable disorders in all of the fifteen diagnostic classes (or chapters) to just a few possibilities?"

Further, the *DSM-5* text is organized from front cover to back cover in a way that is intended to help us answer this question. The chapters appear in a relatively specific, useful order that helps us with our diagnostic decision making. They are ordered in a way that can guide our diagnostic thought process. You can see the order by thumbing through pages xiii–xl of the *DSM.* What makes the order of the chapters useful to us? It presents the different types of disorders in a chapter sequence based on each class of disorder's "underlying vulnerability" and "symptom similarity" as well as in a manner reflecting a life span developmental trajectory. In other words, as much as possible, classes or chapters that share some features appear

near each other in the front to back order of the text. Take another look at the order of the classes of disorders appearing on pages xiii–xl of the *DSM-5*. You will notice the following contents:

First Considerations: Neurodevelopmental Disorders and Schizophrenia Spectrum Disorders

According to the *DSM-5*'s interchapter design, the first two chapters to appear both address disruptions in thought and communication, first presenting those experienced early in life span, and then those experienced later. Both chapters warrant the counselor's early attention.

Neurodevelopmental Disorders

As you will see, the Neurodevelopmental Disorders appear first, mostly because they deal with problems of thought, attention, movement, and communication that occur earliest in the life span. When the client is an infant, child, or adolescent, this is a natural starting point. Included are seven different categories: Intellectual Disabilities, Communication Disorders, Autism Spectrum Disorder, Attention-Deficit/Hyperactivity Disorder, Specific Learning Disorder, Motor Disorders, and Other Neurodevelopmental Disorders.

Child therapists, family clinicians, school counselors, and others who work extensively with individuals under age 18 years rely heavily on this chapter. Of particular note, school counselors and their clinical colleagues with child and adolescent caseloads often find the Specific Learning Disorders (Reading, Written Expression, Mathematics), the Autism Spectrum Disorders, and Attention-Deficit Disorders to be especially important to their diagnostic work.

Skill and Learning Exercise 2.4

Becoming Familiar With Neurodevelopmental Disorders

A diagnosis relying on the developmental disorders affecting thought and communication is represented in our case of Naruto, found in Chapter 5.

To increase your understanding of diagnostic decision-making with Neurodevelopmental Disorders, take time now to closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in Naruto's case. It will be helpful to have your copy of the *DSM-5* available as you study the diagnostic aspects of this case illustration. Remember that you are gaining an initial familiarity at this point, not detailed expertise.

At the same time, these disorders are *usually but not always first identified in children, that is, early in the developmental period of the life span.* Therefore, when a counselor can trace an adult client's problematic symptoms affecting thought and communication back to an early life phase with relative certainty, diagnoses found in this chapter may be used. For example, an adult might first be identified with Attention-Deficit/Hyperactivity Disorder (one of the diagnoses in this chapter) during college, providing all of the criteria for onset and the other criteria can be determined. A summary of the Neurodevelopmental Disorders appears on *DSM-5* pages 31–33.

Schizophrenia Spectrum and Other Psychotic Disorders

Next comes a *red flag* chapter. We as authors refer to this as a *red flag* chapter because clinicians commonly believe that if any of these schizophrenia spectrum or other psychotic disorders are present, typically they must be identified, acknowledged, addressed, responded to, or treated first or very early on—that is, when a client or patient is experiencing any of the concerns found in this chapter, commonly it is assumed that this condition will take priority in treatment planning. For new counselors, it is helpful to remember that this chapter comes right after the neurodevelopmental disorders—both chapters deal primarily with disruptions in thought and communication, with the neurodevelopmental disorders usually first appearing early in development and the schizophrenic spectrum and other psychotic disorders occurring next in the life span. However, children may also either be diagnosed with Schizophrenia and/or manifest symptoms of Autism Spectrum Disorder.

Specifically, the *Schizophrenia Spectrum and Other Psychotic Disorders* chapter contains diagnoses for a range of disturbances that share symptoms of psychosis and, hence, use of the word "spectrum": Delusional Disorder, in which the client vehemently holds nonbizarre but untrue beliefs in areas of romance, grandiosity, jealousy, persecution, and so on; Schizophrenia, which is a mixture of psychotic symptoms (delusions, hallucinations) and other characteristically disturbing symptoms (disorganized speech or behavior, disturbed affect, volition, etc.) present intensely for a month and with residual symptoms present for 6 months, causing disturbances in the person's life and not due to another medical condition or other cause; and related problems such as Schizoaffective Disorder, in which the symptoms of both Schizophrenia and a Mood Disorder are troubling the client or patient. The chapter also contains diagnoses for other disturbing psychotic and delusional problems, including Schizotypal Personality Disorder, Brief Psychotic Disorders, Schizophreniform Disorder, and others. Clinicians in medical, psychiatric, and other settings in which these types of symptoms appear may be especially expert with this red flag chapter. A summary of the cardinal features of Schizophrenia Spectrum and Other Psychotic Disorders appears on *DSM-5* pages 87–90. Interestingly, because the symptoms of Schizotypal Personality Disorder are frequently associated with Schizophrenia, this disorder is co-listed in the chapter of Schizophrenia Spectrum and Other Psychotic Disorders.

CLINICAL SPOTLIGHT 2.1: A Career Counseling Client Presenting Psychotic Symptoms?

Why are the schizophrenia spectrum and other psychotic disorders so important to the typical counseling professional? We indicated earlier that certain types of clinicians in specific types of settings might be most likely to use diagnoses for these psychological problems. Often these are medical and psychiatric settings. However, our view is that all counseling professionals must be aware of the red flag disorders in this *DSM-5* chapter and be vigilant about evaluating for them among our client caseload.

As an example, one of the authors (Schwitzer) recalls conducting an intake interview with a college student who came into the university mental health center for career counseling. During the first few sessions, the client reported that he had been having conversations with his deceased grandmother, who was providing consultation and sage advice. He described being able to clearly hear her talking to him. The client came from a Mexican cultural background in which consultation with family ancestors was a normally expected practice. Therefore, as a counselor, there was a diagnostic question as to whether this client was presenting nondiagnosable information about his helpful use of culturally appropriate practices, or, alternatively, whether he was reporting the "red flag" symptoms of a possible psychotic or schizophrenic disorder.

The author followed the diagnostic path suggested by the *DSM.* Further mental status evaluation indicated that, in addition to the auditory experiences (hearing his grandmother), this student also was experiencing the tactile hallucination of feeling as though when he walked, he was stepping several inches above the earth rather than touching the ground with his feet. Follow-up evaluation and psychiatric consultation and referral did, in fact, uncover that the student was experiencing a first incidence of Schizophrenia. Had Schwitzer not begun diagnostically with the red flags—with this career counseling client—he might have missed the correct diagnosis and therefore the needed treatment.

Frequently Diagnosed Classes of Disorders: Bipolar and Related Disorders, Depressive Disorders, Anxiety Disorders, Obsessive-Compulsive and Related Disorders, and Trauma- and Stressor-Related Disorders

Next to appear in the *DSM-5* are five classes of disorders containing arguably the most frequently used sets of diagnoses among contemporary mental health populations: those describing disruptions, distress, or impairment associated with mood or anxiety (Kessler et al., 1994; Seligman, 2004). It should make sense to us that after considering the two chapters dealing with significant and frequent disruptions in thought and communication that we next would turn to the most frequently presented

disorders as we move through our diagnostic decision-making process of comparing the client's presentation to all of the different *DSM* diagnosis criteria sets (as a note, Substance-Related Disorders also are common [APA, 2000a; Kessler et al., 1994; Munson, 2001], but the various classes of disorders associated with mood and anxiety stand out for their prevalence).

Bipolar and Related Disorders

This chapter includes diagnosable syndromes characterized by elevated or irritable mood and the potential for depressed mood (APA, 2013; Frances, First, & Pincus, 1995). It is helpful to notice that the Bipolar and Related Disorders are located between the schizophrenia spectrum and other psychotic disorders, on the one hand, and the depressive disorders, on the other hand, since the bipolar disorders share some symptoms and vulnerabilities with both psychotic disorders and depressive disorders (APA, 2013). Inside the chapter's diagnoses, criteria sets are explained for Manic Episode, Hypomanic Episode, and Major Depressive Episode, and these criteria sets are the building blocks that form the diagnoses. The bipolar disorder criteria sets include primary symptoms and associated symptoms pertaining to feelings as well as thoughts, behaviors, and physiological symptoms; minimum duration and timelines; and severity indicators.

The diagnosable disorders include Bipolar I Disorder, Current or Most Recent Episode Manic; Bipolar I Disorder, Current or Most Recent Episode Hypomanic; Bipolar I Disorder, Current or Most Recent Episode Depressed; Bipolar I Disorder, Current or Most Recent Episode Unspecified; Bipolar II Disorder; Cyclothymic Disorder; and other related disorders. A short summary appears on *DSM-5* page 123.

Depressive Disorders

This important chapter extensively covers diagnosable syndromes characterized by "sad, empty, or irritable mood accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (APA, 2013, p. 155), where mood is defined as "a pervasive and sustained emotion that colors the person's perception of world" (APA, 2000a, p. 825; Frances, First, & Pincus, 1995). The depressive disorder criteria sets include primary symptoms and associated symptoms pertaining to feelings as well as thoughts, behaviors, and physiological symptoms; minimum duration and timelines; and severity indicators.

The diagnosable disorders comprise the newly included Disruptive Mood Dysregulation Disorder; Major Depressive Disorder; Persistent Depressive Disorder; Premenstrual Dysphoric Disorder; Substance/Medication-Induced Depressive Disorder; and other related disorders, as well as depressive disorders that are unspecified, are due to general medical problems, or are due to use of a substance or medication. The chapter also provides extensive specifiers to help the clinician record a very detailed account of the client's experiences, episodes, and disorders. Some of the specifiers, for example, are "Peripartum Onset," indicating the mood disorder began during

pregnancy or within four week of childbirth, and "Seasonal Pattern," indicating episodes of the client's mood problems correspond to seasons of the calendar.

Readers should carefully read *DSM-5* page 155 for a summary of the Depressive Disorders.

Anxiety Disorders

Similar to the chapter on mood disorders, this important chapter extensively covers diagnosable syndromes characterized by excessive anxiety, all of which are associated with symptoms of fear and discomfort and related behavioral consequences. Several different types of anxiety problems are covered. Inside the chapter are: Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder (Social Phobia), Panic Disorder, Agoraphobia, and Generalized Anxiety Disorder. All of these involve some form of cognitive, affective, behavioral, and physiological symptoms of fear, discomfort, and avoidance or other problematic behaviors. Then, rounding out this class of disorders are anxiety disorders due to a general medical condition or substance use and those anxiety disorders not specified elsewhere in the chapter.

Readers should carefully read *DSM-5* pages 189–190 for a summary of the Anxiety Disorders.

Obsessive-Compulsive and Related Disorders

This chapters presents a class of disorders (previously subsumed under the Anxiety Disorders category) characterized primarily by the presence of recurrent and persistent problematic thoughts, urges, or repetitive behaviors, which cause anxiety or other forms of distress or impairment. In other words, this class of disorders focuses on "obsessions" that are persistent, intrusive, unwanted thoughts and images, as well as "compulsions" that are repetitive behaviors or mental acts the client feels urged or compelled to undertake, sometimes in response to unwanted obsessive thinking (APA, 2013, p. 235). Included are: Obsessive-Compulsive Disorders (characterized by the presence of obsessions and/or compulsions); Body Dysmorphic Disorder (in which the obsessive or compulsive focus is on perceived body defects); Hoarding, a new addition to the *DSM* (featuring the perceived need to exhaustively save possessions); Trichotillamania; and the newly included Excoriation (compulsive hair-pulling and skin-picking, respectively).The chapter is rounded out by other related obsessive-compulsive syndromes. Here again, we think readers should carefully read *DSM-5* page 235 for a good summary of the Obsessive-Compulsive Disorders.

Trauma- and Stressor-Related Disorders

The diagnoses comprising this class of disorders (previously subsumed under the Anxiety Disorders category) all share in common the feature of psychological, emotional, or behavioral distress or impairment occurring in reaction to exposures to a traumatic or stressful life event or situation. It is helpful to notice that trauma- and

stressor-related disorders are placed alongside the anxiety disorders (since they share with the anxiety disorders physiological and emotional symptoms of fears and other reactions) and immediately preceding the dissociative disorders (since they share with the dissociative disorders characteristic symptoms pertaining to altered sense of reality).

The chapter first includes two disorders of childhood: Reactive Attachment Disorder and Disinhibited Social Engagement Disorder. With Reactive Attachment Disorder, the child is problematically emotionally withdrawn from adult caretakers, whereas, with Disinhibited Engagement Disorder, the child is problematically uninhibited about approaching unfamiliar adults).

Next are Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder—both of which are diagnosed narrowly only when specific characteristic client symptoms are present, and only in response to events that meet the *DSM* definition of trauma, all of which are explained inside the chapter—and Adjustment Disorder, which, by definition, is "the development of emotional or behavioral symptoms in response to an identifiable stressor" (APA, 2013, p. 286). Just as with Acute Stress Disorder and PTSD, the event and the symptoms must meet a specific diagnostic threshold. With Adjustment Disorder, the person must experience distress related to the life stressor that is beyond what is normally expected, typical for cultural context, and developmentally appropriate—that is, the person's distress must be clinically significant. Readers should see the short summary on *DSM-5* page 265 and also closely review the chapter's discussions of differential diagnoses with PTSD, Acute Stress Disorder, and Adjustment Disorder.

CLINICAL SPOTLIGHT 2.2:
Suicidal Behavior, Mood Disorders, and Adjustment Disorders

One of the authors (Schwitzer) was on call when he responded late at night to the local hospital to interview a man in his early 20s who was brought by ambulance to the emergency room following a suicide attempt. The man had stabbed himself multiple times in his abdomen at a deserted roadside location, and a driver passing by noticed him and called emergency services in time to save his life.

The young man's distress and suicidal behavior were in direct response to a life stressor: He had been stealing small amounts of money from his employer's cash drawer for several months, adding up to a reasonable sum. The employer had eventually noticed the loss and apprehended the young man; now, his parents and family were about to learn of his small crime, he was losing his job, he was in danger of being dismissed from school, and he faced criminal charges. Facing these pressures, the young man had been depressed for more than 2 weeks, lost all interest in academics and social life, had nearly stopped eating and sleeping, felt worthless and guilty, and ultimately attempted to take his life.

In this case, the client's symptoms clearly were in reaction to a life stressor (although of his own making) and certainly beyond what is normally expectable in such situations; however, because his symptoms met the criteria for a Major Depressive Episode, the appropriate diagnosis was Major Depressive Disorder, rather than Adjustment Disorder (see *DSM-5* pages 160–162, 286–287 to compare the criteria). Client cases such as these remind us that diagnosis should assist us to be sure we adequately describe the person's distress or impairment in order to plan the right type and level of needed treatment. It helps us avoid missing the mark for later treatment planning.

Skill and Learning Exercise 2.5

Becoming Familiar With Frequently Diagnosed Bipolar, Depressive, Anxiety, Obsessive-Compulsive, and Trauma- and Stressor-Related Disorders

Many of the disorders associated with mood and anxiety are represented in our popular culture caseload. We recommend that you closely read these *DSM-5* chapters in their entirety and then turn to our case illustrations. Remember that you are gaining an initial familiarity at this point, not detailed expertise.

To increase your understanding of diagnostic decision-making with Bipolar Disorders, take time now to closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in the case of Annie Wilkes. To increase your understanding of diagnostic decision-making with Persistent Depressive Disorder, take time now to closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in the cases of Edward Cullen, Cleveland Brown, and Jack McFarland. To increase your understanding of diagnostic decision-making with Anxiety Disorders, read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in Belle's case. To increase your understanding of diagnostic decision-making with Trauma- and Stressor-Related Disorders, closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in the cases of Maria and Miss Celie.

It will be helpful to have your copy of the *DSM-5* available as you study the diagnostic aspects of these case illustrations.

Classes of Disorders With Shared Phenomenological Features

Following the first-considerations chapters and the frequently diagnosed classes of disorders, the *DSM-5* presents a series of classes of disorders that are organized by similarity of symptoms, also referred to as shared phenomenology of features (Neukrug

& Schwitzer, 2006). The idea is that we might first consider whether one or more of the two initial chapters dealing with disruptions in thought best account for the client's presentation; then, we can move on next to consider whether, instead, one or more of the frequently diagnosed disorders related to mood or anxiety might be the best description. When these are ruled out or do not fully cover the client's situation, we progress through the various classes that appear next. They include the following classes or chapters:

- ***Dissociative Disorders,*** which feature gradual or sudden, temporary or chronic, disruptions in previously well-functioning consciousness, memory, identity, or perception (the term *dissociation* is defined on *DSM-5* page 820, and the disorders are summarized on pages 291–292).

- ***Somatic Symptom and Related Disorders,*** which share as a common feature the presence of distressing physical symptoms suggesting a medical condition, along with "abnormal thoughts, feelings, and behaviors in response to these symptoms" (a summary is found on *DSM-5* pages 309–310; examples are Illness Anxiety Disorder, featuring distressing or impairing preoccupation with acquiring an illness, and Somatic Symptom Disorder, featuring physical medical symptoms that result in clinically significant life disruption or psychological distress).

- ***Feeding and Eating Disorders,*** all of which share characteristic disturbances in thoughts, feelings, behaviors, or physiology associated with eating behavior, body perceptions, or weight management. Included are the eating/feeding disturbances of Pica, Rumination Disorder, and Avoidant/Restrictive Food Intake Disorder (addressing persistently eating nonfood substances, persistently regurgitating food, and clinically persistent lack of interest in eating, respectively)—as well as the clinically important eating disorders of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Eating Disorder; see *DSM-5* page 329 for a short summary and review pages 338–354 for comparisons of anorexia, bulimia, binge-eating disorder, and other specified eating disorders.

- ***Elimination Disorders,*** which focus on clinically significant inappropriate elimination of urine or feces, and usually are first diagnosed in childhood or adolescence. These include Enuresis (inappropriate voiding of urine), Encopresis (passage of feces in inappropriate places), and Other Specified Elimination Disorders.

- ***Sleep-Wake Disorders,*** all of which share characteristic disturbances in the area of sleep-wake rhythms that result in client presentations concerning problems or dissatisfaction with amount, quality, and timing of sleep—as well as resulting clinically significant daytime distress or impairment; Insomnia Disorder, Hypersomnolence Disorder, Breathing-Related Sleep Disorders; and Nightmare Disorder are examples (see *DSM-5* pages 361–362 for a summary).

- ***Sexual Dysfunctions,*** all of which share characteristic disturbances in the area of sexuality, namely, disturbances in sexual desire, response, or performance, which result in a person's inability to satisfactorily respond sexually or experience

sexual pleasure and therefore cause clinically significant distress or interpersonal difficulties; disorders associated with sexual arousal/interest, orgasm or ejaculation, and negative effects of substance or medication use are examples (see *DSM-5* pages 423–424 for a summary).

- ***Gender Dysphoria,*** a newly included diagnostic class presenting the single diagnosis of Gender Dysphoria, or clinically significant incongruence between the individual's experienced or expressed gender, and their biological or assigned gender, either in children (Gender Dysphoria in Children) or adolescents or adults (Gender Dysphoria in Adolescents and Adults); see *DSM-5* page 451 for a detailed summary.

- ***Disruptive, Impulse-Control, and Conduct Disorders,*** which present diagnosable conditions centering on problems with behavioral and emotional self-control—including Oppositional Defiant Disorder (describing problematic patterns of angry mood and argumentative behavior), Intermittent Explosive Disorder (recurrent behavioral outburst and inability to control aggressive impulses), and Conduct Disorder (a pattern of violating the rights of others through aggression, destructiveness, and rule violation), as well as Pyromania, Kleptomania, and other specified and unspecified disruptive, impulse-control, and conduct disorders. As with the Neurodevelopmental Disorders, child therapists, family clinicians, school counselors, and others who work extensively with individuals under age 18 years might rely heavily on some of the diagnoses in this chapter. Readers should see the summary found on *DSM-5* pages 461–462 and review pages 462–476 for a comparison of Oppositional-Defiant, Intermittent Explosive, and Conduct Disorders. Interestingly, because the symptoms of Antisocial Personality Disorder are "closely connected to the spectrum of externalizing conduct disorders in this chapter" (APA, 2013, p. 476), this disorder is co-listed in the chapter of Disruptive, Impulse Control, and Conduct Disorders.

- ***Substance-Related and Addictive Disorders,*** an extensive chapter that contains all of the disorders associated with clinically problematic substance use (Substance Use Disorder), and with clinically significant problems that are substance induced. Specifically, substance-induced diagnoses are provided for intoxication and withdrawal; substance-induced psychotic disorders; substance-induced bipolar, depressive, and anxiety disorders; sleep disorders and sexual dysfunctions; delirium; and neurocognitive disorders. Also appearing is the "non-substance-related addictive disorder" Gambling Disorder, new to the *DSM,* which features persistent gambling behavior causing clinically significant impairment or distress. Naturally, professionals working in settings for which substance-use and substance-induced problems (or problematic gambling) are especially prominent will need to become masters of this chapter. You will find a helpful one-page summary of the whole class of Substance-Related Disorders on *DSM-5* page 482 and a chapter summary on page 481.

- ***Neurocognitive Disorders,*** a class of disorders all referring to prominent clinical disturbances that must be due to (a) a specific, physiological/medical

condition for which there is evidence from medical history, physical examination, or laboratory findings; (b) the effects of a substance, including a drug of abuse, medication, or exposure to a toxin; or (c) a combination of these. Effects of a medical condition in the form of Delirium means that the client or patient is experiencing a disturbance in his or her conscious awareness of self and orientation to the world around him or her (the etiology of the delirium, such as Substance Withdrawal Delirium or Delirium due to a Specific Medical Condition, is included in the mental disorder diagnosis). Effects of a medical condition in the form of a Mild Neurocognitive Disorder or Major Neurocognitive Disorder means the person is experiencing (mild or major) cognitive decline in domains such as attention, executive function, learning and memory, language perception and motor abilities, and social cognition. Two of the chapter's prominent examples are Mild or Major Neurocognitive Disorder Due to Alzheimer's Disease, and Mild or Major Neurocognitive Disorder Due to Traumatic Brain Injury. Here, professionals working in settings for which Delirium Due to Substance Use or Medical Condition, Dementia Due to Alzheimer's Disease, or Dementia Due to Traumatic Brain Injury are especially prominent will need to become experts using this chapter. You will find a helpful summary table of neurocognitive domains on *DSM-5* pages 593–595 and a chapter summary on pages 591–592.

- ***Personality Disorders,*** a diagnostic class in which the individual diagnostic syndromes all refer to problems stemming from entrenched, pervasive, inflexible personality patterns that lead to intrapersonal distress and/or interpersonal impairment. Personality disorders are discussed further in our textbook's next section.

- ***Paraphilic Disorders,*** which all share in common distress or interpersonal impairment resulting from an intense, persistent, inflexible sexual interest outside of genital stimulation or preparatory sexual stimulation; for instance, two examples are clinically significant client situations arising from Voyeuristic Disorder (intense recurrent sexual arousal from spying or observing unsuspecting others who are naked, disrobing, or engaged in sexual activity) and Exhibitionistic Disorder (recurrent sexual arousal from sexually exposing oneself to others). Frotteuristic Disorder (a pattern of sexually touching a nonconsenting person) and Pedophilic Disorder (a pattern of sexual behavior with prepubescent children) both appear in this chapter (see *DSM-5* pages 685–686 for a full summary).

- ***Other Mental Disorders,*** a residual category presented following the other diagnostic classes, which provides an opportunity for clinicians to document client presentations that meet the threshold of clinically significant distress and/or impairment but do not meet any of the diagnostic categories found among any of the other *DSM-5* classes of disorders. Specific diagnostic options in this chapter are Other Specified Mental Disorder Due to Another Medical Condition; Unspecified Mental Disorder Due to Another Medical Condition; Unspecified, Other Specified Mental Disorder; or Unspecified Mental Disorder (see *DSM-5* pages 707–708).

Skill and Learning Exercise 2.6

Becoming Familiar With Several Diagnostic Classes of Disorders

Several of these classes of diagnoses are represented in our popular culture caseload found in Chapter 5. We recommend that you closely read the various chapters in their entirety and then turn to our case illustrations. Remember that you are gaining an initial familiarity at this point, not detailed expertise.

To increase your understanding of diagnostic decision-making with *Sexual Dysfunctions* and *Substance Use and Addictive Disorders,* take time now to closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in the case illustration of Cleveland Brown.

To increase your understanding of diagnostic decision-making with *Neurocognitive Disorders,* take time now to closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in the case illustration of Sophia.

It will be helpful to have your copy of the *DSM-5* available as you study the diagnostic aspects of these case illustrations.

More About Personality Disorders

As can be seen in our preceding discussion, Personality Disorders comprise one of the classes of disorders found among the chapters of mental disorders with shared phenomenological features. Because of their complexity and clinical impact, Personality Disorders require some additional discussion at this point. When determining the diagnosis of a Personality Disorder or considering that a client manifests features of a Personality Disorder (but not the full presence of a diagnosable personality disorder), the counseling professional is answering the following questions:

> "Does the client evidence any long-term pattern of maladaptive [personality] traits that cause significant impairment or distress?" and "Does the client have [signs and symptoms that] meet criteria for any of the [personality disorders specified in the *DSM-5*]?" (La Bruzza & Mendez-Villarrubia, 1994, p. 86)

Personality consists of "habitual and predictable patterns of human behavior, thinking, and feeling" that are believed to result from a combination of physiological influences and psychosocial developmental influences; generally speaking, it is expected that personality undergoes a more flexible formation phase earlier in our lives, and then as we reach adolescence, early adulthood, and adulthood, our unique predictable personality pattern firms up (American Counseling Association, 2009, p. 398). When an individual's personality patterns lead to clinically significant difficulties, a Personality Disorder may be diagnosed. More specifically, a Personality Disorder comprises

> an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment. (APA, 2013, p. 645)

Note that as with other diagnosable mental disorders, the *DSM-5* diagnostic system includes only those personality difficulties that are outside what is normally expectable given the person's life context, appropriate for the person's developmental context, or acceptable given the person's cultural context. Further, diagnosable difficulties must cause clinically significant impairments in the person's intrapersonal or interpersonal life. In addition, by definition, these patterns must be long-term ones that emerge in adolescence and early adulthood and persevere through the life span, not just during times of stress or crisis.

Each diagnosis requires disruptions in cognition (ways of perceiving, thinking about, and interpreting self, others, or events), affect (range, intensity, and appropriateness of emotions), interpersonal relationship behavior, and control of impulses. Each diagnosis is made only when the pattern is not better accounted for by another diagnosable mental disorder, and when the pattern is not due to the physiological effects of substance use or a medical problem. The *DSM-5* contains 12 different diagnosable personality disorders. They all appear together in one chapter. You can find them summarized on *DSM-5* pages 645–646.

For our convenience—to help us work our way through this class of diagnoses—the personality disorders are divided up in the *DSM-5* into three categories based on descriptive similarities among the personality disorder diagnoses. The *DSM* text calls these categories *Clusters,* which are differentiated more on the basis of the intrapsychic and interpersonal themes shared by the diagnoses than on the basis of symptoms per se. In addition, there is one category for patterns that do not fall into any of the ones described. The diagnosable personality disorders are as follows:

Cluster A: Odd and Eccentric Patterns. Three specific personality disorders are in this category: Paranoid, Schizoid, and Schizotypal. The characteristic they share is that clients presenting these disorders often appear odd or eccentric.

> ***Paranoid Personality Disorder*** is characterized by a long-term, maladaptive, inflexible pattern of distrust and suspiciousness. Clients presenting this disorder interpret others' motives to be malevolent.
>
> ***Schizoid Personality Disorder*** is characterized by a long-term, maladaptive, inflexible pattern of detachment from social relationships, along with significantly restricted range of emotional expression.
>
> ***Schizotypal Personality Disorder*** is characterized by a long-term, maladaptive, inflexible pattern of severe discomfort in close personal relationships, along with acute restriction in emotional expression.

Cluster B: *Dramatic, Emotional, Erratic Patterns.* The four personality disorders in this category are Antisocial, Borderline, Histrionic, and Narcissistic. The characteristic

they share is that individuals experiencing these disorders often appear dramatic, emotional, or erratic in their behaviors, reactions, and relationships.

Antisocial Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of clinically significant and diagnosable disregard for, and violation, of the rights of others.

Borderline Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of unstable interpersonal relationships, unstable self-image, unstable emotional reactions, and problematic impulsiveness.

Histrionic Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of excessive emotional reaction and affective expression, and excessive attention-seeking across situations.

Narcissistic Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of grandiose self-image, need for admiration from others, and poor empathy for the situation or experiences of others.

Cluster C: Anxious and Fearful Patterns. The three personality disorders in this category are Avoidant, Dependent, and Obsessive-Compulsive. The characteristic they share is that persons dealing with these disorders often appear anxious, inhibited, or fearful.

Avoidant Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of social inhibition, feelings of being inadequate, and severe hypersensitivity to negative evaluations and reactions from others.

Dependent Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of overly submissive and problematically clinging behavior that is related to an excessive need to be taken care of in life by others.

Obsessive-Compulsive Personality Disorder is characterized by a long-term, maladaptive, inflexible pattern of being excessively preoccupied with orderliness, perfectionism, and control.

Other Specified Personality Disorder and Unspecified Personality Disorder. Along with the 10 specific disorders outlined earlier, the *DSM-5* provides two additional personality disorder diagnoses: ***Other Specified Personality Disorder*** and ***Unspecified Personality Disorder.*** These diagnoses are used when the client presents a disorder pertaining to personality functioning that does not meet the criteria of any other personality disorder. The person might have symptoms of several different personality disorders that do not fully meet any one criteria list, but together cause clinically significant distress and/or impairment. The person sometimes may exhibit a diagnosable personality pattern that is not captured by the ones described. Likewise, **Personality Change Due to Another Medical Condition** also is included in the chapter.

Personality Disorder Features. This diagnostic chapter also may be used to record personality features that are prominent and maladaptive for the person but do not meet the full criteria of a personality disorder diagnosis. When one focus of the counseling relationship is to assist the person with the effects of maladaptive personality features, or when it might be clinically useful to the person's current or future counselors, these features are recorded along with the rest of the diagnosis.

Before leaving this discussion of Personality Disorders, it is also important to note that because the various personality disorders share overlapping symptoms and patterns of functioning, the *DSM-5* Personality Disorders Task Force had originally planned to dimensionalize personality disorders. They ultimately did not; however, you want to review pages 761–781, which present an "Alternative *DSM-5* Model for Personality Disorders" that may lay the groundwork for revisions to the category in subsequent iterations of the *DSM*.

Skill and Learning Exercise 2.7

Becoming Familiar With Personality Features

The diagnostic practice of recording personality disorder features is demonstrated in our popular culture caseload found in Chapter 5. We recommend that you closely read the *DSM* chapter in its entirety, and then turn to our case illustrations. Remember that you are gaining an initial familiarity at this point, not detailed expertise.

To increase your understanding of diagnostic decision-making with this section, take time now to closely read or re-read the intake summary, diagnostic impressions, and diagnostic discussion found in the following case illustrations: The Beast's Belle, Annie Wilkes, and Jack McFarland. It will be helpful to have your copy of the *DSM-5* available as you study the diagnostic aspects of these case illustrations.

Figure 2.3 *DSM-5* Helpful Interchapter Organization

Initial Considerations: The first two chapters share vulnerability in the areas of thought and communication (Nock, 2013):	
Neurodevelopmental Disorders	Clinical disturbances ranging from specific to global deficits in learning, intellect, and communication, with onset during developmental phase of the life span
Schizophrenia Spectrum and Other Psychotic Disorders	Clinical disturbances of thought and communication predominated by psychotic symptoms such as hallucinations, delusions, or disorganized behavior
Frequent Outpatient Diagnostic Classes (Nock, 2013; Seligman, 2004): These classes all address commonly seen client disruptions in mood or anxiety:	
Bipolar and Related Disorders	Includes all of the Bipolar I and Bipolar II Disorders with Manic, Hypomanic, or Major Depressive Episodes
Depressive Disorders	Includes all of the commonly diagnosed depressive disorders and their specified subtypes

Frequent Outpatient Diagnostic Classes (Nock, 2013; Seligman, 2004): These classes all address commonly seen client disruptions in mood or anxiety:	
Anxiety Disorders	Includes all of the commonly diagnosed anxiety disorders featuring excessive fear, panic, and behavioral consequences
Obsessive-Compulsive and Related Disorders	Includes all the commonly diagnosed disorders featuring persistent unwanted thoughts (obsessions) and repetitive behaviors (compulsions).
Trauma- and Stressor-Related Disorders	Includes all disorders based on exposure to or adjustment to a traumatic or stressful event
Classes Organized by Shared Similarity of Features (Neukrug & Schwitzer, 2006): These classes follow those noted above in the *DSM* text and, often, in diagnostic decision-making:	
Dissociative Disorders	All pertain to disruptions in consciousness, memory, identity, perception
Somatic Symptom and Related Disorders	All pertain to symptoms suggesting a medical condition
Feeding and Eating Disorders	All pertain to disturbances in feeding or eating-related behavior
Elimination Disorders	All pertain to disturbances in elimination of urine or feces
Sleep-Wake Disorders	All pertain to disturbances in the behavior and physiology of sleep and sleep-wake rhythms
Sexual Dysfunctions	All pertain to disruptions in sexual desire, response, or behavior
Gender Dysphoria	All pertain to cognitive discontent with one's gender
Disruptive, Impulse-Control, and Conduct Disorders	All pertain to problems involving emotional or behavioral self-control or self-regulation
Substance-Related and Addictive Disorders	All pertain to psychological symptoms due a substance use (or a non-substance-related addiction)
Neurocognitive Disorders	All pertain to clinical disturbances in consciousness or cognition
Personality Disorders	All pertain to problems stemming from entrenched, pervasive, inflexible personality patterns, which lead to intrapersonal distress and/or interpersonal impairment
Paraphilic Disorders	All pertain to problematic intense persistent sexual interests
Other Mental Disorders	All pertain to diagnosable client experiences not attributable to another *DSM-5* diagnosis

The Clinical Disorders: Intrachapter Organization—What's Inside Each Chapter?

We said above that it is important to learn about two aspects of the *DSM-5* in order to navigate it successfully when making clinical disorder diagnoses. Now that we have discussed the interchapter organization, we turn to intrachapter organization. In other words, we turn to what is inside each clinical disorder chapter. This is important because once the counselor has tentatively narrowed his or her diagnostic impressions to the most likely class of disorders (or a few likely classes), the next task is to compare and contrast the various diagnoses found within the class. This requires our familiarity with what is inside each chapter. As a help to clinicians, all of the various *DSM* chapters are organized almost identically. Although there are some differences—for example, the substance use and addictive disorder chapter includes an important table summarizing what are diagnosable disorders for different substances—for the most part, once we understand what is inside one of the chapters, we can confidently make our way through all of them.

As a brief summary, you can usually expect to find the following elements provided for each of the diagnoses in each clinical disorder chapter: Diagnostic Criteria, given inside a set-aside box; Subtypes and Specifiers; Coding and Recording Procedures; Diagnostic Features; Associated Features Supporting the Diagnosis; Prevalence; Development and Course; Risk and Prognostic Factors; Culture-Related and Gender-Related Issues; Suicide Risk or Other Risk Factors; Functional Consequences; Differential Diagnosis; and Comorbidity.

Diagnostic Criteria and Diagnostic Features. The *DSM* discussion of each diagnosable disorder in each class, or chapter, begins with a set-off box presenting the exact diagnostic criteria—followed by a detailed narrative presenting the disorder's essential features, the criteria to be considered, and other information about client presentations and the clinical picture pertaining to the diagnosis. This diagnostic narrative fully explains inclusionary criteria (exactly what features must be seen in the client's presentation, which features are essential to the diagnosis, and how many of the various criteria must be met), exclusionary criteria (what conditions would rule out the diagnosis), minimum duration the client must have experienced symptoms or minimum frequency of the symptoms needed for the diagnosis, symptom severity, and other features of the criteria. As examples, a diagnosis of Major Depressive Disorder requires the presence of five or more symptoms from a list, but among these five, either depressed mood or loss of interest and pleasure must be seen; a diagnosis of Generalized Anxiety Disorder requires a minimum duration of 6 months of symptoms; and a diagnosis of Schizophrenia excludes psychotic symptoms that are due to substance use. Although certainly it is tempting to rush right into a diagnosis based solely upon the criteria list, our view is that it is critical to explore all of the important diagnostic information found in the narrative that follows the criteria list, in order to better understand the disorder's features, associated features, subtypes and specifiers, differential diagnoses, recording procedures—and whatever other relevant information is available.

Subtypes and Specifiers. Subtypes and specifiers are used to increase the descriptive power of our diagnoses. There are three kinds of specifiers: severity specifiers, course specifiers, and descriptive features specifiers. *Severity specifiers* are provided whenever the full criteria for a diagnosis are met, to describe the degree to which the client's concerns are causing distress or interfering with his or her functioning. Generally, a severity specifier of "Mild" indicates the person's symptoms are not in excess of those needed to make a diagnosis; "Moderate" is a midrange indicator; and "Severe" specifies that the person's symptoms are in excess of those needed to make the diagnosis, that some of the symptoms are especially severe, or when the symptoms are especially debilitating. *Course specifiers* are used to describe the course, duration, or pattern over time of the client's concerns. Generally speaking, the course specifier "In Partial Remission" indicates the person previously was experiencing a full set of diagnostic criteria, but currently only some symptoms remain. Similarly, "In Full Remission" is added to indicate that at this time no signs of previously diagnosed disorder remain. For example, when our client has recently experienced a manic episode meeting the criteria for Bipolar I Disorder, but currently is successfully taking medication and experiencing no difficulties, it might be clinically useful to use this specifier to indicate that although the person is currently experiencing no symptoms, his or her previous symptoms are important to note. Likewise, as another example, there are several course specifiers to help describe the situation of a client who was previously diagnosed with Substance Use Disorder, but who currently is not experiencing the full criteria for this diagnosis. The counselor can add: "Early" or "Sustained" Remission, indicating whether the person has been free of Substance Dependence for less than or longer than 12 months; or "In a Controlled Environment," indicating the person has been in recovery while being in inpatient treatment or incarcerated, respectively. *Descriptive features specifiers* are used to provide additional information describing a specific client's presentation or experience of a disorder. For example, when our client is experiencing Obsessive-Compulsive Disorder, we may indicate if the degree to which the individual recognizes his or her obsessive-compulsive beliefs are irrational or untrue, indicating "With Good or Fair Insight," "With Poor Insight," or "With Absent Insight/Delusional Beliefs." Similarly, *Subtypes* are provided for many *individual diagnoses.* Subtypes describe mutually exclusive groupings within a diagnosis (APA, 2013; p. 21). For example, subtypes of Adjustment Disorder are used to indicate whether the disorder is occurring "With Depressed Mood," "With Anxiety," and so on. Likewise, subtypes for the eating disorder diagnosis, Anorexia, include "Restricting Type" (indicating that weight loss is due mainly to not eating) and "Binge-Eating/Purging Type" (indicating that weight loss is due mainly to vomiting, laxative use, or similar means).

Severity, course, descriptive features, and subtype specifiers give the counselor greater ability to describe diagnostically the exact key features an individual is experiencing.

Coding and Recording Procedures. Usually two types of recording procedures are given for each diagnosis: one explaining how to record subtypes and specifiers, and one explaining how to record the *DSM-5*/*International Classification of Diseases, Tenth*

Edition (ICD-10) numerical code that goes along with each diagnosis. First, instructions are given for writing out the subtypes and specifiers. For example, with Major Depressive Disorder, we find that the diagnosis is completed by adding the course and severity specifier, as follows:

- Major Depressive Disorder, Single Episode, Moderate.

Next, instructions are given for writing out the numerical code, which is shorthand for the clinical disorder diagnoses. The codes themselves are given with the name of each diagnosis throughout the *DSM-5* and can be easily found in the text. In the example of Major Depression, adding the numerical codes would result in the following clinical disorder diagnosis:

- 296.22 (F32.2) Major Depressive Disorder, Single Episode, Moderate.

Associated Features Supporting the Diagnosis. Once the main diagnostic criteria and features have been explained and the instructions provided for recording the diagnosis, next the *DSM-5* provides information about associated features. These are clinical features that are not really criteria for a particular psychological disorder but are known to frequently occur in association with the disorder. For example, this section tells us that for a severe eating disorder such as Anorexia, additional features might occur, including depressed mood, social withdrawal, or irritability. Knowing this information can help us more confidently and accurately evaluate and describe the client's presentation and needs. Although this information is valuable, associated features are not actually part of the diagnostic criteria for the disorder with which they are associated.

Prevalence. When information about prevalence is known for a diagnosis, it is provided. Prevalence might be described based on 12-month occurrence in the general United States population; in comparison with international populations such as occurrence in Europe; occurrence among specific populations such as clinical populations; or based on other clinically valuable data. For instance, the *DSM-5* indicates that Schizoaffective Disorder is more commonly diagnosed among females than among males.

Development and Course. When information about how the symptoms of a diagnosis are experienced and evolve over the course of a disorder is known, it is provided. This information can be useful to making reliable, accurate diagnoses.

Risk and Prognostic Factors, and Suicide Risk. The *DSM-5* discussion of a diagnosis also may include information about the risks or vulnerabilities associated with a disorder, the prognosis, or the risk level for self-harm, where applicable. For example, Bipolar Disorder, Major Depressive Disorder, and Cocaine Use Disorder are associated with heightened suicide risk (APA, 2013).

Culture-Related and Gender-Related Issues. Also helpful for making reliable, accurate diagnoses, information pertaining to culture-specific or gender-specific presentations and diagnostic differences are presented when they are known. For example, the *DSM-5* tells us that when considering the diagnosis of Brief Psychotic Disorder, one Culture-Related Issue is that some religious ceremonies among certain cultures involve hearing voices, and these experiences should not be considered when making the diagnosis. Similarly, the *DSM-5* cautions us that cultural and socioeconomic differences between counselor and client must be considered when making the diagnosis of Schizophrenia to avoid misdiagnosis.

Functional Consequences. Along with risk and prognosis, the *DSM-5* also may provide additional information about the likely functional consequences of a disorder in the individual's life. For example, the *DSM* includes social role adjustment problems and various health and medical-related problems as functional consequences of Binge-Eating Disorder. Understanding functional consequences further assists the clinician to accurately understand symptom effects and vulnerabilities associated with various mental health concerns.

Differential Diagnoses. This subheaded section provides guidance that is critical to our diagnostic decision-making. Counseling professionals should carefully review differential diagnosis information during every diagnostic decision-making situation. Differential diagnoses are competing or alternative disorders the clinician should consider before settling on a final diagnosis. Differential diagnoses appear for each clinical disorder and help us avoid overlooking the symptoms of various other psychological disorders our client might be presenting. For example, when diagnosing Posttraumatic Stress Disorder, we are encouraged in the text to alternatively consider Acute Stress Disorder, Major Depressive Disorder, Dissociative Disorder, Adjustment Disorder, and others (APA, 2013) because some of the symptoms and vulnerabilities of these disorders overlap.

Comorbidity. Comorbidity refers to the potential for co-occurrence of a mental disorder with one or more additional mental disorders or with one or more general medical conditions. Competent clinicians must be aware of the potential for comorbidity when it is suggested. For instance, the *DSM-5* reminds us that Major Depressive Disorder frequently co-occurs with substance-related disorders, panic disorder, some eating disorders, and others (APA, 2013). Similarly, the *DSM-5* alerts us that in elderly clients, Neurocognitive Disorder Due to Alzheimer's Disease might co-occur with multiple medical problems, which sometimes complicates our ability to make an accurate diagnosis and accurately determine a prognosis.

Before leaving this discussion on intrachapter organization, it is important to note that these various categories of information, including development and course, and comorbidity and differential diagnosis, are not part of the formal (codable) diagnosis per se, but are instead offered to provide the clinician meaningful information with which he or she can formulate a case conceptualization and treatment plan.

Figure 2.4 *DSM-5* Helpful Intrachapter Organization

What's Inside Each Chapter?
Chapter Introduction and Summary
Diagnostic Criteria, Subtypes and Specifiers, Coding and Recording Procedures
Diagnostic Features
Associated Features Supporting Diagnosis
Prevalence
Development and Course
Risk and Prognostic Factors, and Suicide Risk
Culture-Related and Gender-Related Diagnostic Issues
Functional Consequences
Differential Diagnosis
Comorbidity

A Closer Look at General Medical Conditions

Once we have completed the top element of the diagnosis, namely, the clinical disorder diagnoses, we turn to the remaining elements. Among these, a fully formulated diagnosis provides us an opportunity to list medical problems, physical complaints, and medication needs that are relevant to our client's counseling and psychological concerns. We list these immediately after the mental disorder diagnoses. The medical situations we note on the diagnosis may be directly etiological to (i.e., contributing to or causing) the person's psychological concerns, or there may be another important relationship between the client's physical health problems and mental health concerns. Some examples include hypothyroidism causing a depressive disorder (illustrated in our text by the case of Eleanor Rigby in Chapter 5), the stressful effects of having asthma on a client's adjustment, the threatening presence of hypertension (high blood pressure) in a client's medical history, or the presence of HIV infection when relevant to counseling concerns. In addition to information about physical and medical problems, at this point in the diagnosis we can record any prescribed medications the client is taking when those medications are clinically relevant or may have psychological or psychiatric side effects. It is at this second point in a fully formulated diagnosis that the clinician answers the questions:

> "Are there any physical signs and symptoms present?" "Does the client have a documented history of any [relevant] injuries or medical disorders?" and "Could a general medical condition be causing the clinical problem noted [in the diagnosis]?" (LaBruzza & Mendez-Villarrubia, 1994, pp. 86–87)

Mental health professionals working in hospital, medical, inpatient, psychiatric, or other clinically oriented settings may be required to provide formal general medical condition diagnoses in their diagnostic formulation. Medical (as opposed to

psychological or psychiatric) diagnoses are accompanied by the appropriate *ICD-10-CM* code and are formally presented. For example, formal General Medical Condition records for a client dealing with exposure to the HIV virus, and another client dealing with asthma, might read as follows:

Z20.6 Contact with and expected exposure to HIV virus and

J45.3 Mild Persistent Asthma

When they are needed, *ICD-10* codings can be retrieved online and are available in most relevant workplaces; many work settings also provide staff with helpful lists of many of the most common general medical conditions and their *ICD* codes. Conversely, it is likely that most counseling professionals working in typical outclient and outpatient settings can record acceptable information about medical conditions using less formal notations, provided they are written professionally and accurately. For example, many of us in typical counseling settings would note our clients with HIV exposure and asthma as follows:

Suspected exposure to the HIV virus

and

Asthma

At this spot in the diagnosis, various problems associated with medication side effects (e.g., problems associated with initial encounters with antidepressant medications) also may be listed when relevant. A specific description of these is provided right in the *DSM-5* text on pages 709–714.

Skill and Learning Exercise 2.8

Becoming Familiar With General Medical Conditions

Several of the clients in our popular culture caseload (Chapter 5) present medical conditions relevant to their counseling concerns.

To increase your understanding of diagnostic recordings of general medical conditions, take time now to closely read or re-read the intake summaries, diagnostic impressions, and diagnostic discussions for Naruto, Cleveland Brown, and Eleanor Rigby, and then answer the following questions:

Why was it clinically relevant to record Naruto's sprained ankle on the diagnosis? Why might it have been clinically relevant to list Cleveland Brown's borderline hypertension? Why was it essential to record Eleanor Rigby's hypothyroid condition?

What types of medical conditions do you think your own future clients are most likely to present? Remember that you are gaining an initial familiarity at this point, not detailed expertise.

A Closer Look at Psychosocial and Environmental Problems

Next, the diagnostic formulation provides us opportunity to list psychosocial problems and problems and conditions pertaining to the social environment that might have an impact on our client's counseling concerns, especially as they affect the mental disorder diagnoses we have identified. Often these problems have an effect on how we conceptualize and plan for treatment and the prognosis for positive counseling outcomes. It is by listing psychosocial and environmental stressors and problems that the counselor answers the questions:

> "What psychosocial or environmental problem is the client facing?" "What stressors are currently taxing the client's ability to cope?" "How is the client meeting such basic needs as survival, food, shelter, clothing, safety, education, employment, friendship, affection, social interaction, and self-esteem?" and "What is the client's social support system and how well is it functioning?" (LaBruzza & Mendez-Villarrubia, 1994, p. 87)

Answering these questions, some of the stressors commonly recorded at this point on the diagnosis are losses; positive and negative life events, transitions, and changes; emotionally significant events; and anniversaries of emotionally significant events (LaBruzza & Mendez-Villarrubia, 1994). More specifically, to complete this step in the diagnostic formulation, clinicians should refer to the *DSM-5* section titled "Other Conditions That May Be a Focus of Clinical Attention" found on *DSM-5* pages 715–727. In this section, the *DSM-5* identifies several categories of common social problems and environmental stressors. Included are Relational Problems associated with family upbringing (e.g., Parent-Child and Sibling Relational Problems) and primary support groups (problems with spouse, divorce, etc.); Abuse and Neglect (i.e., physical, sexual, or psychological abuse or neglect of a child, partner, or other adult); Educational and Occupational Problems; Housing and Economic Problems (homelessness, extreme poverty, etc.); and Problems Related to Crime or Interaction With the Legal System. Further, the *DSM-5* includes a variety of additional common social environment problems (such as Phase of Life Problem, Acculturation Difficulty, and being a Target of Discrimination); circumstance problems (such as Unwanted Pregnancy); and circumstances in one's personal history (such as History of Military Deployment or History of Self-Harm). Encounters with additional health and counseling services, problems accessing medical care, nonadherence with medical treatment, and other health concerns (obesity, wandering) also are included. In sum, as described under "Other Conditions That May Be Focus of Counseling," at this point in the diagnosis, clinicians record relevant concerns associated with the following:

- Relational Problems
- Abuse and Neglect
- Educational and Occupational Problems
- Housing and Economic Problems
- Other Problems Related to the Social Environment

- Problems Related to Crime or Interaction With the Legal System
- Other Health Service Encounters for Counseling and Medical Advice
- Problems Related to Other Psychosocial, Personal, and Environmental Circumstances
- Other Circumstances of Personal History

As a technical matter, counseling professionals most often record these items by listing the problem itself in a careful, professional manner. The following is a simple example:

- Other Factors: Problem with an unwanted pregnancy

However, some professional settings require a more formal preparation using the full *DSM-5* entry and accompanying code(s), all of which are easily found right in the *DSM* text in the "Other Conditions That May Be a Focus of Clinical Attention" section. The following is an example:

- Other Factors: V61.7 (Z64.0) Problems Related to Unwanted Pregnancy

Counseling professionals also utilize Other Conditions That May Be a Focus of Clinical Attention within the diagnosis when:

- The problem is the focus of counseling or treatment, but the person is not experiencing any diagnosable mental disorder (e.g., a student seeking consultation about an Academic Problem, or an elderly client seeking counseling related to a Problem Living Alone)
- The individual is experiencing a diagnosable psychological disorder, but it is unrelated to or separate from the counseling topic (e.g., a client dealing with lifelong Persistent Depressive Disorder, who comes in for consultation about Discord With Neighbor)

Psychosocial and environmental information, like medical and health information, adds importantly, when relevant, to our description of the client's experiences, life situation, and counseling needs.

Skill and Learning Exercise 2.9

Becoming Familiar With Other Social and Environmental Factors

A variety of clients in our popular culture caseload present psychosocial and environmental problems relevant to their counseling concerns. We recommend that you closely read the *DSM* section found on pages 717–725, and then turn to our 10 case illustrations. Remember that you are gaining an initial familiarity at this point, not detailed expertise.

To increase your understanding of other social and environmental factors, take time now to briefly read or quickly re-read the intake summaries and diagnostic impressions for as many cases as you can—and then answer the following questions:

(Continued)

(Continued)

What are some of the most common or most important psychosocial problems found among our 10 client illustrations? What are some of the most common or most important environmental problems found among our 10 clients? Are they problems with the clients' primary support group? Educational or occupational problems? Housing, economic, or health care access problems? Crime and incarceration problems? Others?

What types of psychosocial and environmental problems do you think your own future clients are most likely to present?

A Closer Look at Assessment of Functioning

The final step of a fully prepared diagnostic report requires us to estimate overall client functioning. It is at this step that counseling professionals are expected to answer the following questions:

> "How well is the client currently functioning in the psychological, social, and occupational [or academic] aspects of his or her life?" and "How severe are the [person's] current symptoms?" (LaBruzza & Mendez-Villarubia, 1994, p. 87)

Generally speaking, each of the diagnostic formulations or clinical reports a clinician prepares should include assessment of the client's adjustment and resiliencies; functioning in important life roles such as academic or occupational or parenting; and levels of distress, vulnerabilities, symptom severity, and risk (APA, 2013). This information should appear somewhere in the clinical narrative to support and supplement the specific diagnoses selected. Today's professionals might utilize a variety of methods to indicate these assessments. First, using the *DSM-5* diagnostic criteria, counseling professionals may indicate the level of severity—mild, moderate, severe, and so on—associated with the client's presentation for each mental disorder included in the diagnosis. Second, we can employ clinical observations and clinical evaluations, along with behavioral and psychometric assessment instruments, to measure aspects of client symptomotology, distress and impairment, and vulnerability and risk. Third, the *DSM-5* text suggests several additional methods of assessment, including: "cross-cutting symptom measures" (APA, 2013, p. 734), "clinician-rated dimensions of psychosis symptom severity" (APA, 2013, p. 742), and the "World Health Organization Disability Assessment Schedule 2.0" (APA, 2013, p. 745). Students, counseling and psychotherapy professionals in training, and counseling residents should be sure competencies pertaining to testing and measurement are acquired during their professional development (Seligman, 2004).

Skill and Learning Exercise 2.10

Becoming Familiar With Methods of Assessment of Functioning

Methods of assessment are included for all 10 clients in our text's popular culture caseload. We included these in the overall narrative—in the Basic Case Summary, Diagnostic Impressions, Case Conceptualization, or Treatment Plan. In each case, the use of evaluation methods was intended to support and supplement the selection of specific diagnoses and to augment the diagnostic thinking. (As you will see, we identify the relevant assessment measures but in this text do not provide detailed scores or testing data.)

To increase your understanding of the use of assessment of functioning to support the diagnosis, review several of the case narratives found in Chapter 5. Be sure to review the entire narrative, since our approach was to identify assessment measures throughout the case write-up.

What types of measures—diagnostic indicators of severity, behavioral assessments or clinical observations, psychometric instruments—were commonly used? What types of assessment procedures to support diagnoses do you think will most likely be used in your own future professional work settings? Remember that you are gaining an initial familiarity at this point, not detailed expertise.

Pulling It All Together: Deriving a Fully Prepared Diagnosis

Read through a few of the "Discussion of Diagnostic Impressions" sections for any of the 10 popular culture cases in Chapter 5 of our text. In each discussion, you will find brief, start-to-finish examples of how the counseling professional pulls together all of his or her diagnostic skills to derive a comprehensive diagnosis. Certainly, the first step in the learning process is to become familiar with the basics: what the *DSM* system is and is not; what it does and does not do; what is covered and what is not covered; and how the system operates. For students, trainees, and beginning counseling professionals, this is the starting point! However, the next step is to begin pulling it all together and practicing diagnostic decision-making.

Determining Clinical Disorder Diagnoses

By far, most decisions made by a mental health professional, including case conceptualization, treatment planning, and follow-up, derive directly from the appropriate clinical disorder diagnosis. This is where most of our concentration, attention, focus, knowledge, and skill are needed. As we have discussed, the *DSM-5*'s limited scope, and the *DSM-5*'s interchapter organization, should assist us.

Ruling Out. Most of the diagnoses found in the *DSM-5* have "rule-out-oriented" diagnostic criteria, which the system calls "exclusionary criteria" (Munson, 2001, p. 79). Usually our initial job is to rule out—or decide against—some diagnoses based on dimensions our client is not experiencing (APA, 2013). One helpful approach is to initially rule out the presence of disorders with relatively clear biological etiologies or those due to substance use. For instance, Neukrug and Schwitzer (2006) recommended initially ruling out the existence of Schizophrenia Spectrum and Other Psychotic Disorders; Dissociative Disorders; Neurocognitive Disorders; or the presence of either substance use or a medical condition that is causing the client's symptoms of a psychological disorder. We also carefully "rule out" normally expectable reactions, cultural influences, and age-appropriate developmental behaviors, as well as other conditions that might be causing psychological problems but are not diagnosable mental disorders (Munson, 2001).

Differential Diagnoses. We then move from ruling out various conditions to considering differential diagnoses. Differential diagnosis refers to differentiating one diagnosis from other disorders that have some similar presenting characteristic (APA, 2013; Munson, 2001).

Earlier in this chapter, we recommended first considering whether a mood-related or anxiety-related disorder might be present, by attempting to match the client's data with the various bipolar, depressive, anxiety, obsessive-compulsive, or trauma- or stress-related disorders; and next considering whether the client's presentation shares similarities with any of the various classes of disorders organized by area of the psychological disturbance. (Once we have identified the likely classes of disorders, we then look inside the relevant *DSM-5* chapter and use our ruling-out process and differentiation to make a closer decision about which specific disorder, if any, within the diagnostic class best matches the client's exact symptoms.) For example, after we have determined our client is experiencing prominent anxiety symptoms in reaction to a life stressor, next we might try to match his or her recent life experiences with the diagnostic definition of a traumatic event (versus a nontraumatic life stressor, such as with Adjustment Disorder) and match his or her symptoms with the avoidance and re-experiencing symptoms of posttrauma reactions—and then differentiate further by determining that the event occurred within the past month (versus an event occurred beyond the past month, as with PTSD) and that the client's symptoms are mostly dissociative (versus combined symptoms of recurrence, avoidance, reactivity, and/or dissociation). On this basis, we have used a decision-making process based on *ruling out* and *differentiation* to reach a diagnosis of Acute Stress Disorder (at this point, you might want to review *DSM-5* pages 271–290 for a better picture of this Trauma- and Stressor-Related Disorder illustration).

More Than One Diagnosis. As you will see in some of our popular culture examples, often a client is experiencing more than one diagnosable psychological disorder, more than one nondiagnosable condition or focus of counseling, or a combination of multiple entries. When a person presents more than one diagnosable disorder, all

of these diagnoses should be recorded, with the principal or most pressing diagnosis, or main reason for the visit, listed first. The dual rules of parsimony (saying the most with the least—or capturing as many symptoms with the fewest diagnoses) and hierarchy (listing diagnoses in order from most to least explanatory) generally guide our work as diagnosticians.

Indicating Uncertainty. Naturally, we cannot always be certain of our diagnostic impressions. When we believe a diagnosis will be needed to describe the client's needs, but we are currently uncertain about the diagnosis, we have several options. The first option is to record our best estimated diagnosis, followed by the indicator "Provisional Diagnosis." This communicates that we have a diagnosis in mind but believe we need further data to make a conclusion decision. For example:

298.8 Brief Psychotic Disorder With Marked Stressors (Provisional Diagnosis)

The second common option is to defer recording a diagnosis until a later time, such as:

799.9 Diagnosis or Condition Deferred

The third common strategy is to use the category "Unspecified." This indicates we have enough client information to narrow down the class of the disorder we believe the person is experiencing but insufficient data to make a specific diagnosis because the client's presentation does not meet the criteria for any of the exact diagnoses within the class of diagnoses. For example:

301.9 Unspecified Personality Disorder

No Diagnosis. Finally, regarding the clinical diagnoses, when no diagnosis at all, and no nondiagnosable other conditions at all, are to be recorded, we indicate No Diagnosis, as in the following example:

V71.09 No Diagnosis

Rounding Out the Diagnosis

The General Medical Conditions we record and the Psychosocial and Environmental Problems (i.e., Other Factors) we list should round out the information communicated on via the clinical diagnosis. The health condition entries we decide to include should be coexisting medical conditions or physical problems that either are associated with the psychological disorders and conditions we indicated or, if they are independent of the mental health diagnoses, are related to its course and treatment (Munson, 2001). Likewise, the psychological and environmental problems we decide to include should be those other factors or Other Conditions That May Be a Focus of Clinical Attention that have an influence on the "diagnosis, treatment, and

prognosis" of the mental disorders and conditions we identified (Munson, 2001, p. 73). You can review the Diagnostic Impressions and Discussion of Diagnostic Impressions for any of our case illustrations to see how the information in these areas is intended to be related to—and augment or amplify—what we know about our client based on our clinical diagnosis.

Assessment of Functioning

The evaluation information we include in our clinical report is needed to estimate a person's current overall level of functioning, and therefore the assessment, testing, or measurement method or approach we indicate should be a good fit with the diagnoses and conditions we selected. There should be a natural, evidence-based relationship between the main diagnoses and our estimate of overall functioning.

You can review the Basic Case Summary, Diagnostic Impressions, Case Conceptualization, and/or Treatment Plan for any of our case illustrations to see how assessment should relate to what we know about the dimensions of our client's concerns and the related vulnerabilities.

Chapter Summary and Wrap-Up

This chapter started the process of learning to make a psychological disorder diagnosis. We began by putting diagnosis in context and explaining its importance in today's world of professional counseling—and introducing the *DSM-5* diagnostic classification system. We said the *DSM-5* provides a single, comprehensive system of diagnosis used by virtually all of today's counseling and mental health practitioners. We defined *mental disorder* and used it interchangeably with the term *psychological disorder*. We described what is and is not considered a diagnosable disorder; for instance, we said that only client situations that cause clinically significant distress or impairment may be diagnosable. Further, we said normally expectable, culturally determined, and developmentally appropriate behaviors usually are not diagnosed. We also explained the limited purpose of a diagnosis, which is to describe and communicate about the client's situation. We mentioned that a diagnosis, in and of itself, does not indicate etiology, theoretical conceptualization, professional viewpoint, or treatment. These factors were summarized in Figure 2.1. We also presented some of the major counselor reservations about making diagnoses, and described how the *DSM* system attempts to address these. Important considerations included potential for bias, potential for stigmatization or labeling, underresponsiveness to social change, overresponsiveness to payment pressure, and advanced clinical criticisms.

We then used the remainder of the chapter to learn about the *DSM-5* diagnostic system. We presented four different sets of information that comprise a fully formulated diagnosis: Clinical Disorders (which are the top element of the diagnostic process); General Medical Conditions; Psychosocial and Environmental Problems or Other Factors; and Assessment of Functioning. We said that the psychological

disorder diagnosis answers questions about whether the client shows signs and symptoms of conditions contained in the *DSM-5*; medical condition information answers questions about the presence of physical problems and health symptoms; descriptions of interpersonal contextual issues explain the psychosocial and environmental problems and other stressors the client is facing; and assessment supports the diagnosis by answering questions about the client's symptom severity and vulnerabilities, and how well the client currently is functioning in the psychological and social and occupational or academic aspects of his or her life. These were summarized in Figure 2.2.

We explained how to use the *DSM-5*'s interchapter and intrachapter organization to evaluate for the 22 classes of diagnosable disorders comprising several hundred separate disorders, as well as other conditions that can be a focus of counseling. We described the diagnostic features, subtypes and specifiers, coding and recording procedures, associated features supporting the diagnosis, prevalence, development and course, risk and prognostic factors, culture-related and gender-related issues, functional consequences, differential diagnoses, and comorbidity information provided. This was summarized in Figures 2.3 and 2.4.

We then pulled together all of this information to show how to make a complete diagnosis. We discussed diagnostic decision-making, including ruling-out conditions and considering differential diagnoses. We explained how to indicate more than one diagnosis, uncertainty among diagnoses, and no diagnosis. We discussed how to make determinations and what to record regarding medical conditions and psychosocial and environmental factors so that this information corresponds with and enhances our clinical diagnosis impressions. Last, we discussed inclusion of assessment data to support and supplement the diagnosis.

Throughout the chapter, we referred the reader to specific sections and pages of the *DSM-5*. We relied extensively on our text's case illustrations: We offered many examples and learning activities that used the intake summaries, diagnostic impressions, and discussions of diagnostic impressions found in Chapter 5 of this text.