<u>Chapter 3</u>

Diagnosis in the Assessment Process

Updated and Revised by

Katherine A. Heimsch & Gina B. Polychronopoulos

In Essentials of Testing and Assessment

By Ed Neukrug and Charlie Fawcett

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It was 1975, and part of my job as an outpatient therapist at a mental health center entailed answering the crisis counseling phones every ninth night. I would sleep at the center and answer a very loud phone that would ring periodically throughout the night, usually with a person in crisis on the other end. Every once in a while, a former client of the center would call in and start to read aloud from his case notes, which he had stolen from the center. Parts of these notes were a description of his diagnosis from what was then the second edition of the Diagnostic and Statistical Manual (DSM-II). In a sometimes angry, sometimes funny tone, he would read these clinical terms that were supposed to be describing him. I could understand his frustration when reading these notes over the phone, as in some ways, the diagnosis seemed removed from the person—a label. "Was this really describing the person, and how was it helpful to him?" I would often wonder.

—Ed Neukrug

An important aspect of the clinical assessment and appraisal process is skillful diagnosis. Today, the use of diagnosis permeates the mental health professions, and although there continues to be some question as to its helpfulness, it is clear that making diagnoses and using them in treatment planning has become an integral part of what all mental health professionals do. Thus, in this chapter we examine the use of diagnosis.

We begin this chapter by discussing the importance of diagnosis in the assessment process and then provide a brief overview of the history of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and its evolution over the past several decades. We then introduce the *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5) and note some of the differences from previous versions, such as the use of a single axis and factors that now come into play when making and reporting diagnosis. Next, we highlight the DSM-5 diagnostic categories and follow up with other important considerations when making a diagnosis, such as medical concerns, psychosocial and environmental concerns, and cross-cultural issues. There are several case studies and exercises that will help to hone some of your diagnostic skills. At the

end of the chapter, we relate the importance of formulating a diagnosis within the overall assessment process.

THE IMPORTANCE OF DIAGNOSIS

- John is in fifth grade and has been assessed as having a conduct disorder and attention-deficit/hyperactivity disorder (ADHD). John's mother has panic disorder and is taking antianxiety medication. His father has bipolar and is taking lithium. Jill is John's school counselor. John's individualized education plan (IEP) states that he will work with Jill individually and in small groups to address behavior, attention, and social skills deficits. Jill must also periodically consult with John's mother, father, and teachers.
- Tamara has just started college. After breaking up with her boyfriend, she became severely depressed and unable to concentrate on her schoolwork; her grades have dropped from As to Cs. She comes to the college counseling center and sobs during most of her first session with her counselor. She admits having always struggled with depression but states that "This is worse than ever; I need to get better if I am going to stay in school. Can you give me any medication to help me so I won't have to drop out?"
- Benjamin goes daily to the day treatment center at the local mental health center. He seems fairly coherent and generally in good spirits. He has been hospitalized for schizophrenia on numerous occasions and now takes risperdone to relieve his symptoms. He admits to Jordana, one of his counselors, that when he doesn't take his medication because he believes that computers have consciousness and are conspiring through the World Wide Web to take over the world. His insurance company pays for his treatment. He will not receive treatment unless Jordana specifies a diagnosis on the insurance form.

As you can see from these examples, diagnosis is an essential tool for professionals in a wide range of settings. In fact, current research suggest that up to 20 percent of all children and adults struggle with a diagnosable mental disorders each year (Centers for Disease Control and Prevention [CDC], 2013; Substance Abuse and Mental Health Services Administration, 2012), and approximately 50 percent of adults in the United States will experience mental illness in their lifetime (CDC, 2011). Therefore, all persons serving in helping roles will encounter persons dealing with a mental disorder and will need to be familiar with a common diagnostic language to best serve these individual and to effectively communicate with other professionals. The

importance of an accurate diagnosis is relatively new and is the result of a number of changes that have occurred over the past years. Some of these include the following:

1. Interventions and accommodations for children with emotional, behavioral, and learning disorders are now required by federal and state laws (e.g., PL94-142, Individuals with Disabilities Education Act [IDEA]) and a diagnosis is generally necessary if professionals are to identify students with such disorders. Today, teachers, school counselors, school psychologists, child study team members, and other school professionals are often the first to recognize and diagnose young people with these disorders.
2. Today, a diagnosis is viewed as one aspect of holistically understanding the client. Along with testing, interviews, and other measures, it can be used to help conceptualize client problems and assist in the accurate development of treatment plans.
3. Due to laws like the Americans with Disabilities Act (e.g., United States Department of Justice, n.d.), employers are now required to make reasonable accommodations for individuals with disabilities, including those with mental disorders. Mental health professionals must know about diagnosis if they are to help individuals maintain themselves at work and assist employers in understanding the conditions of individuals with mental disorders.
4. In the past 50 years, a mental disorder diagnosis has generally become mandatory if medical insurance is to reimburse for treatment. Accurate diagnosing is important because the insurance carrier often allows only a certain number of treatments per a particular diagnosis.
5. The diagnostic nomenclature of the DSM has increasingly become an essential and effective way of communicating with community partners who may be part of the client's same treatment team (e.g., other mental health professionals, doctors, representatives of the legal system).
6. It has become increasingly evident that accurately and appropriately communicating a mental health diagnosis to a client can help the individual understand his or her prognosis and aid in forming reasonable expectations for treatment.

These items show why it is important for a wide range of professionals to understand diagnosis. Although the DSM-IV-TR (4th ed. with text revisions; American Psychiatric Association [APA],

2000) had been the most well-known diagnostic classification system, with the recent release of DSM-5 (APA, 2013), a revised nomenclature was developed. But what is the DSM and how does it work?

THE DIAGNOSTIC AND STATISTICAL MANUAL (DSM): A BRIEF HISTORY

Derived from the Greek words *dia* (apart) and *gnosis* (to perceive or to know), the term *diagnosis* refers to making an assessment of an individual from an outside, or objective, viewpoint (Segal & Coolidge, 2001). One of the first attempts to classify mental illness occurred during the mid-1800s when the United States Census Bureau started counting the incidence of "idiocy" and "insanity" (Smith, 2012). However, it was not until 1943 that a formal classification system called the Medical 203 was developed by the U.S. War Department (Houts, 2000). Revised over the next few years, in 1952 this publication became the basis for APA's first DSM (DSM-I), which included 106 diagnoses in 3 broad categories (APA, 1952; Houts, 2000). In 1968 DSM-II was released (APA, 1968), which created 11 diagnostic categories with 185 discrete diagnoses and included a large increase in childhood diagnoses. In an effort to improve the science behind diagnosis as well as increase the compatibility with the American Medical Association's International Classification of Disease (ICD) manual, the third edition of the DSM was released in 1980 (APA, 1980), which included 265 diagnoses and a multiaxial approach to diagnosis. In 1994 DSM-IV was released, and in 2000 an additional text revision of DSM-IV became available (DSM-IV-TR) and contained 365 diagnoses (APA, 1994, 2000). Although there were many critics of the DSM-IV-TR (Beutler & Malik, 2002; Thyer, 2006; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008), it became the most widely utilized diagnostic classification system for mental health disorders (Seligman, 1999, 2004). A DSM-IV diagnosis consisted of five axes that included clinical disorders, personality disorders and mental retardation, medical conditions, psychosocial and environmental factors, and a global assessment of functioning (GAF) scale (see Table 3.1).

TABLE 3.1 Former Five Axis Diagnostic System

Axis	Category	Examples
Axis I	Clinical disorders	Depression, anxiety, bipolar, schizophrenia, etc.
Axis II	Personality disorders and mental retardation	Borderline personality disorder, antisocial personality disorder, etc.
Axis III	General medical conditions	High blood pressure, diabetes, sprained ankle, etc.
Axis IV	Psychosocial and environmental factors	Recent loss of job, recent divorce, homelessness, etc.
Axis V	Global assessment of functioning	A single score from 1 to 100 summarizing one's functioning and symptoms

The practice of utilizing the multiaxial diagnostic system allowed mental health professionals to present a thorough description of clients and communicate their concerns and symptoms to other professionals (Neukrug & Schwitzer, 2006). However, there were drawbacks to a multiaxial approach and the DSM-5 moved toward a one-axis approach.

THE DSM-5

The newest diagnostic manual, DSM-5 (APA, 2013), was under development from 1999 to 2013 (Smith, 2012) and was first published in May of 2013. The DSM-5 includes a sleeker, more computer-friendly name, which replaces the Roman numeral tradition of the DSM. Subsequent editions, like computer software, will follow with editions 5.1, 5.2, 5.3, and so on. In addition to the print version of DSM-5, an online component (www.psychiatry.org/dsm5) is now available for supplemental materials such as assessment measures, but it also includes related news articles, fact sheets, and audiovisual materials. Another important change that has been made to the DSM-5 is an effort to align it with the ICD-9, and later, the ICD-10 (release date: October 1, 2014). This serves to unify the diagnostic and billing process between psychological and medical professions. Thus the DSM-5 gives both the ICD-9 and ICD-10 codes, and when making a diagnosis, one may want to list the ICD-9 code first and place the ICD-10 code in parenthesis. Clearly, it is important to know which version of the ICD is being used when making your diagnosis.

Single-Axis vs. Multiaxial Diagnosis

Perhaps the most significant change in the DSM-5 was the return to a single-axis diagnosis (APA, 2013; Wakefield, 2013). This was done for a number of reasons. First, the separation of personality disorders to Axis II under DSM-IV gave these disorders undeserved status and the misguided belief that they were largely untreatable (Good, 2012; Krueger & Eaton, 2010). Clients who met the criteria for an Axis II diagnosis may now find it easier to navigate mental health treatment as they will no longer be seen as having a diagnosis that is more difficult to treat than a host of other disorders. In DSM-5, medical conditions are no longer listed on a separate axis (Axis III in DSM-IV). Thus, they will likely take a more significant role in mental health diagnosis as they can be listed side-by-side with the mental disorder (Wakefield, 2013). Also, psychosocial and environmental stressors, previously listed on Axis IV of DSM-IV, will be listed alongside mental disorders and physical health issues. In fact, DSM-5 has increased the number of "V codes" (Z codes in ICD-10), which are considered nondisordered conditions that sometimes are the focus of treatment and often are reflective of a host of psychosocial and environmental issues (e.g., homelessness, divorce, etc.). As for the GAF score, previously on Axis V of DSM-IV, the APA intended to replace this historically unreliable tool with a different scaling assessment altogether. One assessment instrument, now being researched, is the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0). This 36-item, self-administered questionnaire assesses a client's functioning in six domains: understanding and communicating, getting around, self-care, getting along with people, life activities, and participation in society (APA, 2013). Disorders and other assessments that are under review for further research can be found in Section III of the DSM-5.

Making and Reporting Diagnosis

In the next section of the chapter, we discuss specific diagnostic categories, but first let's look at other factors involved in making and reporting diagnoses, including how to order the diagnoses; the use of subtypes, specifiers, and severity; making a provisional diagnosis; and use of "other specified" or "unspecified" disorders.

Ordering diagnoses. Individuals will often have more than one diagnosis, so it is important to consider their ordering. The first diagnosis is called the principal diagnosis. In an inpatient setting, this would be the most salient factor that resulted in the admission (APA, 2013). In an

outpatient environment, this would be the reason for the visit or the main focus of treatment. The secondary and tertiary diagnosis should be listed in order of need for clinical attention. If a mental health diagnosis is due to a general medical condition, the ICD coding rules require listing the medical condition first, followed by the psychiatric diagnosis, due to the general medical condition.

Subtypes, Specifiers, and Severity. Subtypes for a diagnosis can be used to help communicate greater clarity. They can be identified in the DSM-5 by the instruction "Specify whether" and represent mutually exclusive groupings of symptoms (i.e., the clinician can only pick one). For example, the ADHD has three different subtypes to choose from: predominantly inattentive, predominantly hyperactive/impulsive, or a combined presentation. Specifiers, on the other hand, are not mutually exclusive, so more than one can be used. The clinician chooses which specifiers apply, if any, and they are listed in the manual as "Specify if." The ADHD diagnosis offers only one specifier that is "in partial remission" (APA, 2013, p. 60). Some diagnoses will offer an opportunity to rate the severity of the symptoms. These are identified in the DSM as "Specify current severity." Referencing the ADHD diagnosis, there are three options of severity: mild, moderate, or severe. The DSM-5 authors have attempted to offer greater flexibility in rating severity through *dimensional diagnosis*. For example, some diagnoses offer greater options when rating severity. The Autism Spectrum Disorder has "Table 2 Severity levels of autism spectrum disorder" (APA, 2013, p. 52), which classifies autism on three levels of severity "requiring support," "requiring substantial support," and "requiring very substantial support." Similarly, schizophrenia has the user go to a "Clinician-Rated Dimensions of Psychosis Symptom Severity" chart (pp. 743–744) to rate symptoms on a five-point Likert scale. It is easy to see how insurance companies might use severity classification as one method of determining which clients they will fund for treatment. In summary, the three types of specifiers are identified by:

- Subtype: "*Specify whether*"—only choose one,
- Specifier: "*Specify if*"—pick as many as apply, and
- Severity: "*Specify current severity*"—choose the most accurate level of symptomology.

Provisional Diagnosis. Sometimes, the clinician has a strong inclination that a client will meet the criteria for a diagnosis, but does not yet have enough information to make the diagnosis. This is when the clinician can make a *provisional* diagnosis. Once the criteria are later

confirmed, the provisional label can be removed. These situations often occur when a client is not able to give an adequate history or further collateral information is required. In addition, there are informal diagnostic labels not listed in the DSM-5 that are helpful in communicating additional information. They are generally found in a diagnostic summary or when communicating informally with other clinicians. They include the following:

- Rule-out—the client meets many of the symptoms but not enough to make a diagnosis at this time; it should be considered further (e.g., rule-out major depressive disorder).
- Traits—this person does not meet criteria, however, he or she presents with many of the features of the diagnosis (e.g., borderline traits or cluster B traits).
- By history—previous records (another provider or hospital) indicate this diagnosis; records can be inaccurate or outdated (e.g., alcohol dependence by history).
- By self-report—the client claims this as a diagnosis; it is currently unsubstantiated; these can be inaccurate (e.g., bipolar by self-report).

For example, you may receive a fax from a hospital or other provider that might say, "Provisional Borderline Personality Disorder. Bipolar Diagnosis by self-report—no manic symptoms identified."

Other Specified Disorders and Unspecified Disorders. The DSM-IV had a diagnosis of not otherwise specified (NOS) to capture symptomology that did not fit well into a structured category. In lieu of the NOS diagnosis, the DSM-5 offers two options when these situations arise. The other specified and unspecified disorders should be used when a provider believes an individual's impairment to functioning or distress is clinically significant, however, it does not meet the specific diagnostic criteria in that category. The "other specified" should be used when the clinician wants to communicate specifically why the criteria do not fit. The "unspecified disorder" should be used when he or she does not wish, or is unable to, communicate specifics. For example, if someone appeared to have significant panic attacks but only had three of the four required criteria, the diagnosis could be "Other Specified Panic Disorder—due to insufficient symptoms." Otherwise, the clinician would report "Unspecified Panic Disorder."

SPECIFIC DIAGNOSTIC CATEGORIES

Section II of DSM-5 offers an in-depth discussion of 22 broad diagnostic categories and their subtypes as well as descriptions of medication-induced disorders and what is called "other

conditions that may be a focus of clinical attention." The following offers a brief description of these disorders and is summarized from DSM-5 (APA, 2013). Please refer to the DSM-5 for an in-depth review of each disorder. When you finish reviewing these diagnoses, the class may want to do Exercise 3.1.

- *Neurodevelopmental Disorders.* This group of disorders typically refers to those that manifest during early development, although diagnoses are sometimes not assigned until adulthood. Examples of neurodevelopmental disorders include intellectual disabilities, communication disorders, autism spectrum disorders (incorporating the former categories of autistic disorder, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder), ADHD, specific learning disorders, motor disorders, and other neurodevelopmental disorders.
- *Schizophrenia Spectrum and Other Psychotic Disorders.* The disorders that belong to this section all have one feature in common: psychotic symptoms, that is, delusions, hallucinations, grossly disorganized or abnormal motor behavior, and/or negative symptoms. The disorders include schizotypal personality disorder (which is listed again, and explained more comprehensively, in the category of Personality Disorders in the DSM-5), delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, schizoaffective disorder, substance/medication-induced psychotic disorders, psychotic disorders due to another medical condition, and catatonic disorders.
- *Bipolar and Related Disorders.* The disorders in this category refer to disturbances in mood in which the client cycles through stages of mania or mania and depression. Both children and adults can be diagnosed with bipolar disorder, and the clinician can work to identify the pattern of mood presentation, such as rapid-cycling, which is more often observed in children. These disorders include bipolar I, bipolar II, cyclothymic disorder, substance/medication-induced, bipolar and related disorder due to another medical condition, and other specified or unspecified bipolar and related disorders.
- *Depressive Disorders.* Previously grouped into the broader category of "mood disorders" in the DSM-IV-TR, these disorders describe conditions where depressed mood is the overarching concern. They include disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (also known as dysthymia), and premenstrual dysphoric disorder.

- *Anxiety Disorders.* There are a wide range of anxiety disorders, which can be diagnosed by identifying a general or specific cause of unease or fear. This anxiety or fear is considered clinically significant when it is excessive and persistent over time. Examples of anxiety disorders that typically manifest earlier in development include separation anxiety and selective mutism. Other examples of anxiety disorders are specific phobia, social anxiety disorder (also known as social phobia), panic disorder, and generalized anxiety disorder.
- *Obsessive-Compulsive and Related Disorders.* Disorders in this category all involve obsessive thoughts and compulsive behaviors that are uncontrollable and the client feels compelled to perform them. Diagnoses in this category include obsessive-compulsive disorder, body dysmorphic disorder, hoarding disorder, trichotillomania (or hair-pulling disorder), and excoriation (or skin-picking) disorder.
- *Trauma- and Stressor-Related Disorders.* A new category for DSM-5, trauma and stress disorders emphasize the pervasive impact that life events can have on an individual's emotional and physical well-being. Diagnoses include reactive attachment disorder, disinhibited social engagement disorder, posttraumatic stress disorder, acute stress disorder, and adjustment disorders.
- *Dissociative Disorders.* These disorders indicate a temporary or prolonged disruption to consciousness that can cause an individual to misinterpret identity, surroundings, and memories. Diagnoses include dissociative identity disorder (formerly known as multiple personality disorder), dissociative amnesia, depersonalization/derealization disorder, and other specified and unspecified dissociative disorders.
- *Somatic Symptom and Related Disorders.* Somatic symptom disorders were previously referred to as "somatoform disorders" and are characterized by the experiencing of a physical symptom without evidence of a physical cause, thus suggesting a psychological cause. Somatic symptom disorders include somatic symptom disorder, illness anxiety disorder (formerly hypochondriasis), conversion (or functional neurological symptom) disorder, psychological factors affecting other medical conditions, and factitious disorder.
- *Feeding and Eating Disorders.* This group of disorders describes clients who have severe concerns about the amount or type of food they eat to the point that serious health problems, or even death, can result from their eating behaviors. Examples include avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, binge eating disorder, pica, and

rumination disorder.

- *Elimination Disorders.* These disorders can manifest at any point in a person's life, although they are typically diagnosed in early childhood or adolescence. They include enuresis, which is the inappropriate elimination of urine, and encopresis, which is the inappropriate elimination of feces. These behaviors may or may not be intentional.
- *Sleep-Wake Disorders.* This category refers to disorders where one's sleep patterns are severely impacted, and they often co-occur with other disorders (e.g., depression or anxiety). Some examples include insomnia disorder, hypersomnolence disorder, restless legs syndrome, narcolepsy, and nightmare Disorder. A number of sleep-wake disorders involve variations in breathing, such as sleep-related hypoventilation, obstructive sleep apnea hypopnea, or central sleep apnea. See the DSM-*5* for the full listing and descriptions of these disorders.
- *Sexual Dysfunctions.* These disorders are related to problems that disrupt sexual functioning or one's ability to experience sexual pleasure. They occur across sexes and include delayed ejaculation, erectile disorder, female orgasmic disorder, and premature (or early) ejaculation disorder, among others.
- *Gender Dysphoria.* Formerly termed, "gender identity disorder," this category includes those individuals who experience significant distress with the sex they were born and with associated gender roles. This diagnosis has been separated from the category of sexual disorders, as it is now accepted that gender dysphoria does not relate to a person's sexual attractions.
- *Disruptive, Impulse Control, and Conduct Disorders.* These disorders are characterized by socially unacceptable or otherwise disruptive and harmful behaviors that are outside of the individual's control. Generally, more common in males than in females, and often first seen in childhood, they include oppositional defiant disorder, conduct disorder, intermittent explosive disorder, antisocial personality disorder (which is also coded in the category of personality disorders), kleptomania, and pyromania.
- *Substance-Related and Addictive Disorders.* Substance use disorders include disruptions in functioning as the result of a craving or strong urge. Often caused by prescribed and illicit drugs or the exposure to toxins, with these disorders the brain's reward system pathways are activated when the substance is taken (or in the case of gambling disorder, when the behavior

is being performed). Some common substances include alcohol, caffeine, nicotine, cannabis, opioids, inhalants, amphetamine, phencyclidine (PCP), sedatives, hypnotics or anxiolytics. Substance use disorders are further designated with the following terms: intoxication, withdrawal, induced, or unspecified.

- *Neurocognitive Disorders.* These disorders are diagnosed when one's decline in cognitive functioning is significantly different from the past and is usually the result of a medical condition (e.g., Parkinson's or Alzheimer's disease), the use of a substance/medication, or traumatic brain injury, among other phenomena. Examples of neurocognitive disorders (NCD) include delirium, and several types of major and mild NCDs such as frontotemporal NCD, NCD due to Parkinson's disease, NCD due to HIV infection, NCD due to Alzheimer's disease, substance- or medication-induced NCD, and vascular NCD, among others.
- *Personality Disorders.* The 10 personality disorders in DSM-5 all involve a pattern of experiences and behaviors that are persistent, inflexible, and deviate from one's cultural expectations. Usually, this pattern emerges in adolescence or early adulthood and causes severe distress in one's interpersonal relationships. The personality disorders are grouped into three following clusters based on similar behaviors:
    - Cluster A: Paranoid, schizoid, and schizotypal. These individuals seem bizarre or unusual in their behaviors and interpersonal relations.
    - Cluster B: Antisocial, borderline, histrionic, and narcissistic. These individuals seem overly emotional, are melodramatic, or unpredictable in their behaviors and interpersonal relations.
    - Cluster C: Avoidant, dependent, and obsessive-compulsive (not to be confused with obsessive-compulsive disorder). These individuals tend to appear anxious, worried, or fretful in their behaviors.

  In addition to these clusters, one can be diagnosed with other specified or unspecified personality disorder, as well as a personality change due to another medical condition, such as a head injury.
- *Paraphilic Disorders.* These disorders are diagnosed when the client is sexual aroused to circumstances that deviate from traditional sexual stimuli *and* when such behaviors result in harm or significant emotional distress. The disorders include exhibitionistic disorder, voyeuristic disorder, frotteurisitc disorder, sexual sadism and sexual masochism disorders,

fetishistic disorder, transvestic disorder, pedophilic disorder, and other specified and unspecified paraphilic disorders.

- *Other Mental Disorders.* This diagnostic category includes mental disorders that did not fall within one of the previously mentioned groups and do not have unifying characteristics. Examples include other specified mental disorder due to another medical condition, unspecified mental disorders due to another medical condition, other specified mental disorder, and unspecified mental disorder.
- *Medication-Induced Movement Disorders and Other Adverse Effects of Medications.* These disorders are the result of adverse and severe side effects to medications, although a causal link cannot always be shown. Some of these disorders include neuroleptic-induced parkinsonism, neuroleptic malignant syndrome, medication-induced dystonia, medication-induced acute akathisia, tardive dyskinesia, tardive akathisia, medication-induced postural tremor, other medication-induced movement disorder, antidepressant discontiunation syndrome, and other adverse effect of medication.
- *Other Conditions That May Be a Focus of Clinical Assessment.* Reminiscent of Axis IV of the previous edition of the DSM, this last part of Section II ends with a description of concerns that could be clinically significant, such as abuse/neglect, relational problems, psychosocial, personal, and environmental concerns, educational/occupational problems, housing and economic problems, and problems related to the legal system. These conditions, which are not consider mental disorders, are generally lised as V codes, which correspond to ICD-9, or Z codes, which correspond to ICD-10.

Sometimes, mental health conditions can co-occur or be “comorbid.” For example, suppose a client presents with an anxiety disorder but also abuses alcohol. In this situation, it would be appropriate to denote both disorders when making a diagnosis (e.g., generalized anxiety disorder and alcohol abuse). Sometimes disorders can even exacerbate each other. An example of this could be someone who meets the criteria for depression, but his or her symptoms only present while withdrawing from cocaine use. Rather than diagnosing this as a major depressive episode, it is more appropriate that he or she be diagnosed with a *substance-induced* mood disorder (see Exercise 3.1).

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EXERCISE 3.1**: Diagnosing a Disorder**

Once the class has become familiar with the various disorders, the instructor may ask the students to practice identifying and diagnosing disorders by performing role-plays in dyads or small groups. You may want to use DSM-5 as a guide for acting out the criteria.

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Other Medical Considerations

Sometimes, physical symptoms caused by a medical condition may look a lot like one or more of the mental disorders. For example, some of the symptoms for depression include appetite disturbance (increase or decrease), irritability or restlessness, hyper or insomnia (i.e., sleeping too much or too little), difficulty concentrating, and fatigue or decreased energy. Interestingly, all of these symptoms can also be attributed to hypothyroidism or underactive thyroid. Thus, in addition to clients being assessed for mental health problems, it is also important for them to be assessed for potential medical problems. One way to address this is to obtain specific details about when the client began experiencing his or her symptoms. Such information will help determine whether symptoms began while a medical condition was present and whether it is likely that the medical condition was the cause of the mental disorder. For instance, suppose you have a client who is presenting with all of the criteria for an anxiety disorder (such as restlessness, irritability, and insomnia), but you know that these symptoms began when the client's thyroid began declining and he or she found out it was underactive. If the client's anxiety disorder only came about because of the hypothyroidism, then it would be appropriate to designate it as such, that is, anxiety disorder due to a general medical condition, hypothyroidism. Of course, it is always prudent to refer a client to his or her primary care physician if there is any suspicion that a medical problem may be the source of a psychological issue (see Exercise 3.2). If reporting a medical problem, the ICD code for the particular problem can be used along with the DSM-5 mental health disorder diagnosis.

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EXERCISE 3.2 **DIAGNOSING MEDICAL CONDITIONS**

After practicing formulating a diagnosis in Exercise 3.1, the instructor may ask the students to role-play again, incorporating a medical condition this time. Identify the medical condition as well as the mental health condition, and be sure to note whether it is separate or if it is the cause of the mental health diagnosis.

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PSYCHOSOCIAL AND ENVIRONMENTAL CONSIDERATIONS

As a part of a complete diagnosis, it is imperative for the clinician to assess the client's psychosocial and environmental stressors. Such a focus promotes a holistic view of the client, provides important diagnostic clues, and can help to identify important issues in treatment planning. Not considered mental disorders, some of the many psychosocial and environmental concerns may include problems with the client's primary support group, social environment, education, occupation, housing, economic situation, access to health care, crime or the legal system, or other significant psychosocial and environmental considerations (APA, 2013). Whereas these concerns were previously listed on Axis IV of DSM-IV, they are now denoted in the single-axis system, are mostly listed under "Other conditions that may be a focus of clinical attention" discussed earlier, and are correlated to V codes in DSM-5 (which matches ICD-9) or Z codes (which matches ICD-10) (e.g., Z59.0 Homelessness; Z65.1 Imprisonment; Z55.3 Underachievement in school).

To illustrate the importance of psychosocial and environmental considerations, consider a 48-year-old male experiencing severe anxiety and depression. He explains that his symptoms started immediately after a tornado caused severe damage to his home and neighboring farm (natural disaster). The man and his family have been staying with relatives about 70 miles away from home (homelessness), and have had no source of income for the past three months (economic issues) since their crop of soy was also destroyed in the tornado (occupational problem). By understanding the client's psychosocial and environmental considerations, his anxiety and depression can be viewed in the context of his life circumstances.

CULTURAL CONSIDERATIONS

Because people from diverse cultures may express themselves in different ways,

symptomatology may vary as a function of culture (Mezzich & Caracci, 2008). Thus, some have argued that although diagnosis can be helpful in treatment planning, it can lead to the misdiagnosis of culturally oppressed groups when clinicians do not fully take into account cultural, gender, and ethnic differences (Rose & Cheung, 2012; Eriksen & Kress, 2005, 2006, 2008; Kress, Eriksen, Rayle, & Ford, 2005; Madesen & Leech, 2007).

The APA (2013) has attempted to combat some of these problems by asking clinicians to understand and acknowledge "culturally patterned differences in symptoms" (p. 758). For example, Latin American culture acknowledges that *ataque de nervios* ("attack of nerves") is a common disorder related to difficult and burdensome life experiences and may exhibit itself through "headaches and 'brain aches' (occipital neck tension), irritability, stomach disturbances, sleep difficulties, nervousness, easy tearfulness, inability to concentrate, trembling, tingling sensations, and *mareos* (dizziness with occasional vertigo-like exacerbations)" (p. 835). A clinician who ignores the client's culture could easily misdiagnose a client who presents with symptoms like this and begin to treat the client with inappropriate strategies. Best practice for multicultural counseling suggests that the clinician have some understanding of differences in cross-cultural expression of symptoms and that the clinician explore the client's culture with him or her when deciding on appropriate treatment strategies.

Finally, DSM-5 offers a section entitled Cultural Formulation Interview (CFI) that helps clinicians understand the kinds of values, experiences, and influences that have come to shape the client's worldview and provides an outline for how to appropriately interview clients from diverse backgrounds. In addition, DSM-5 offers definitions of some cross-cultural symptoms and identifies how cross-cultural issues impact a wide-range of diagnoses.

FINAL THOUGHTS ON *DSM-5* IN THE ASSESSMENT PROCESS

DSM-5 is one additional piece of the total assessment process. Along with the clinical interview, the use of tests, and informal assessment procedures, it can provide a broad understanding of the client and can be a critical piece in the treatment planning process. Consider what it might be like to establish a treatment plan if only one test were used. Then, consider what it would be like if two tests were used, then two tests and an informal assessment procedure; then two tests, an informal assessment procedure, and a clinical interview; and finally, two tests, an informal assessment procedure, a clinical interview, and a diagnosis. Clearly, the more "pieces of

evidence" we can gather, the clearer our snapshot of our client becomes and this, in turn, yields better treatment planning (see Exercise 3.3).

EXERCISE 3.3 **PRACTICE MAKING A DIAGNOSIS**

On your own, in pairs, or as a class, read the following case studies and formulate a diagnosis for each person using the DSM-5 as a guide. Discuss how you came to this diagnosis, what other diagnoses you considered but ruled out, and what additional information would have been helpful in assessing the scenario. Answers can be found at the end of the chapter.

Mikayla

Mikayla is an 8-year-old girl in the second grade. She lives with her parents and younger brother, and her mother describes her as "a handful, but very sweet." Mikayla had to repeat second grade due to behavioral issues in class, which also resulted in lower test scores and poor grades. She is a popular child among her peers, but she continually struggles with her teacher to follow directions, stay on task, and remain seated. Mikayla's teacher has consulted with her kindergarten and first-grade teachers and does not think that Mikayla has communication issues or a specific learning disorder because she performs above grade-level expectations in small group or with one-on-one attention. In a large classroom situation, she is in constant motion, shouts when she should be talking quietly, and is easily distracted, which prevents her from meeting expectations. Most recently, Mikayla was referred to the school counselor after she broke the classroom fish tank during a silent reading activity. "I was just trying to feed Flipper," she explained.

Tracey

Tracey is a 25-year-old single working mother. Her daughter, Alicia, is three years old and in day care during the work week. Tracey was recently divorced from Alicia's father and has sole custody of their child because her ex-husband was physically abusive. In the past few years, when the marital problems began, Tracey has been overwhelmed with anxiety but is so busy that she "just doesn't have time to deal with it." She starts her day at 5:30 a.m. to get Alicia dressed, packed, and ready for day care so that she can get to work by 7:00 a.m. Tracey usually has breakfast on the road, and she frequents the drive-through on her way to work for convenience. At work it's "go, go, go," and Tracey doesn't usually have time to break for lunch. By the time she picks up Alicia from day care and gets home, it's about 6:00 p.m. Tracey cooks dinner by 7:00 p.m., which usually consists of a healthy, balanced meal. Once she gives Alicia a bath and puts her to bed, Tracey finally gets a breather to relax on the couch and watch TV. Now that she is alone, she feels an uncontrollable urge to snack and often goes through a large bag of potato chips followed by a pint of ice cream before she realizes it. Sometimes, she finishes eating that amount before her favorite half-hour sitcom is over. "I just can't stop. It's like I zone out, and I don't even realize how much I've eaten. I feel like I can't control myself. Usually, I feel physically sick by the end of it and just pass out, like a food coma." Tracey doesn't like to eat junk food in front of others because she's ashamed that she has gained so much weight since the divorce and feels self-conscious. She's been eating in secret like this for the past year since the divorce, and it happens almost every night. It's gotten to the point where she has begun isolating herself, preferring to go home and snack all night in front of the TV instead of spending time with family and friends.

Alan

Alan is a 37-year-old banker, who was divorced from his wife two years ago. Alan reported that his wife left him after he became disengaged from the marriage. He recalled that he and his wife were college sweethearts and were previously very active in their community. Then, approximately five years ago, Alan said, “I just ran out of steam.” He has since been constantly irritable, started sleeping excessively, gained about 45 pounds, and lost interest in being social and engaging in pleasurable activities. Alan smokes marijuana approximately two to four times per day and drinks vodka nightly to “relax and take my mind off of things.” He recently was arrested for possession of marijuana and driving under the influence, put on probation for one year, and was referred to counseling by the court. Alan admits to being mildly depressed, but insists, “It’s nothing I can’t handle.” He does not wish to discontinue his marijuana or alcohol use but has thoughts about stopping due to monthly drug screens, which will soon be required by his probation officer.

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SUMMARY

We began this chapter by discussing the importance of a diagnosis for a wide-range of mental health professionals. We noted that a large percentage of Americans are diagnosed, yearly, with a mental disorder, and highlighted some reasons that diagnosis has become important for professionals, such as their significance in identifying children in schools with emotional, behavioral, and learning disorders; the fact that a diagnosis can help in case conceptualization and treatment planning; the fact that professionals can help employers make accommodations for and understand individuals with mental disorders; because they are critical to insurance reimbursement; because they assist professionals in accurately communicating to one another; and because they can help clients understand their prognosis and expectations for treatment planning.

Next, we offered a brief history of the DSM starting with the United States Census Bureau counting those who were “idiots” and “insane” during the mid-1800s. However, we noted that it wasn’t until 1943, with the military’s Medical 203, that a formal classification system was developed. We then noted that DSM-I was developed in 1952 and underwent a number of revisions up through the most recent edition, the DSM-5 in 2013. We then introduced the *DSM-5* and began noting some of the differences from its predecessors, particularly the move from a five-axes system in DSM-IV to a one-axis system in DSM-5.

A large portion of the chapter described DSM-5. We began by explaining why DSM-5 moved to a one-axis system and discussed making and reporting a diagnosis. In this process, we

discussed how to order diagnoses; the use of subtypes, specifiers, and severity; how to make a provisional diagnosis; and the use of other specified or unspecified disorders. Next, we offered very brief descriptions of the 22 diagnostic categories. We also offered a brief discussion about co-occurring or comorbid disorders. This was followed by a discussion about the importance of understanding how medical conditions can cause or exacerbate a diagnosis. We then noted that whereas psychosocial and environmental considerations were placed on Axis IV of DSM-IV, they are now correlated to an ICD code, are often given a V or Z code, and included in the single-axis system. Finally, we noted that individuals may present symptoms in varying ways as a function of their culture and talked about the importance of taking into consideration one's cultural background when making a diagnosis. We pointed out that DSM-5 offers a Cultural Formulation Interview (CFI) that can help in the process of understanding diverse clients, provides some examples of cross-cultural symptoms, and identifies how cross-cultural issues impact a wide range of diagnoses. We ended the chapter by noting that DSM-5 is one piece in the total assessment process and offered an exercise where students could try to diagnoses three hypothetical clients.

Chapter Review

1. Consider how a mental health diagnosis could be beneficial to a client. What might be potential harm from a diagnosis?
2. Why is it important for clinicians, medical doctors, legal professionals, and so on to use a common diagnostic language?
3. Explain why it is an ethical responsibility for clinicians to be knowledgeable about diagnosis.
4. Give examples of how you might utilize a diagnosis when formulating a treatment plan.
5. Describe how medical conditions can be relevant to a mental health diagnosis.
6. Describe how psychosocial and environmental considerations are now included in DSM-5.
7. Explore how you can include multicultural considerations into a diagnosis.
8. Discuss the difference between use of subtypes, specifiers, and severity.
9. Explain how provisional diagnoses can be made.

10. Discuss the use of other specified or unspecified disorders.
11. Describe how a one-axis system can be used to encapsulate all of the five axes from DSM-IV.
12. Identify a diagnosis from any category that makes you personally feel uncomfortable. Explore where these feelings come from and how you might go about working with a client who has this diagnosis.

Answers to Exercise

I. 314.01 (F90.2) Attention-deficit hyperactivity disorder, combined presentation;
Other factors: V62.3 (Z55.9) Academic underachievement.

II. 307.51 (F50.8) Binge eating disorder, moderate;
Other factors: V61.03 (Z63.5) Disruption of family by divorce (recent); V60.2 (Z59.7) Low income; V62.9 (Z60.9) Unspecified problem related to social environment: Social isolation.

III. 300.4 (F34.1) Persistent depressive disorder (dysthymia);
303.90 (F10.20) Alcohol use disorder, moderate;
304.30 (F12.20) Cannabis use disorder, moderate;
Other factors: V61.03 (Z63.5) Disruption of Family by Divorce (two years ago); V62.5 (Z65.0) Conviction in civil or criminal proceedings without imprisonment: Probation.

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There are many reasons to diagnose

DSM-I

First edition published in 1952 with three broad categories

DSM-III

Introduced multiaxial diagnosis in 1980

DSM-IV (TR)

Used a five-axial diagnosis

DSM-5

Accepted diagnostic classification system for mental disorders

Single-axis

Attempt to make clinical diagnoses and personality disorders on par with medical codes

V & Z codes

Allows psychosocial stressors to be listed in diagnosis

Primary diagnosis

The reason the person came to treatment is listed first

Subtype

"*Specify whether*"—only choose one

Specifier

"*Specify if*"—pick as many as apply

Dimensional diagnosis

Offers ability to note symptom severity

Severity

"*Specify current severity*"—choose the most accurate level of symptomology

Provisional diagnosis

Used when strong inclination but can't yet confirm

Other specified disorder

Doesn’t fit a standard diagnosis with an explanation why not

Unspecified disorder

Doesn’t fit a standard diagnosis without explanation

Be cognizant of medical factors that may influence mental health

Diagnostic categories

Twenty-two categories included in one axis

Co-occurring disorders

Disorders may coexist and can sometimes exacerbate one another

Medical conditions

Can list, using ICD codes, along with DSM diagnosis

Psychosocial/environmental factors

Stressors that are crucial for understanding the whole person

Cultural considerations

Use CFI and info from DSM to understand differences in symptomatology

Some “abnormal” behaviors may be considered “normal” in other cultures

Diagnosis adds clarity to the assessment process