2 DIAGNOSIS

Understanding and Using the DSM-5-TR

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, Text Revision* (*DSM-5-TR*)** (American Psychiatric Association [APA], 2022) is an essential skill in today's mental health workplace. 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. In everyday practice, this means that practitioners, including professional counselors and psychotherapists, clinical social workers and psychologists, and psychiatrists, are expected to be proficient using the *DSM-5-TR* 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, 2014; Seligman, 2004). In fact, given the modern need for "practitioners from different professions working together and combining their knowledge to provide integrated services," 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-TR* in order to be effective in the multidisciplinary settings in which they work (Johnson & Mahan, 2020, p. 2).

At the same time, learning to manage the *DSM-5-TR* diagnostic classification system can seem especially daunting for new counselors: After all, the text comprises more than nine hundred pages, contains hundreds of diagnoses, and weighs almost four pounds! Correspondingly, chapter 2 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-TR* classifications and their use with various client populations.

Next, we present the *DSM-5-TR*'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

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activities and clinical snapshots, highlight cutting-edge themes in our Intersections and Screenshot boxes, and refer to our twenty clinical cases in order to illustrate our main points about understanding and using the *DSM-5-TR*.

Learning Goals:

In sum, this chapter sets the stage for your professional development in diagnosis. The chapter is designed as an educational foundation, written so that you can develop abilities to recall and explain basic facts, ideas, and concepts related to diagnosis; use what you have learned about diagnosis by applying your knowledge to client scenarios; make connections among the diagnostic ideas you will read about; and begin making your own diagnostic decisions (Anderson et al., 2000). After reading and discussing the chapter, and engaging with the chapter's Skill and Learning Exercises, you will be able to:

- Discuss the role of diagnosis in today's professional counseling settings
- Describe the use of the *DSM-5-TR* 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 using the *DSM-5-TR* for diagnosis with client populations
- Define diagnosable psychological disorder and criterion-referenced
- Demonstrate how to read and understand a fully prepared *DSM-5-TR* diagnosis
- Demonstrate the ability to fully prepare start-to-finish diagnostic impressions using the *DSM-5-TR* text in learning, skill-building, and supervised training contexts that are within the ethical domain of your competency and experience levels.

You might build on your own professional glossary of terms with these phrases from chapter 2:

- ***Diagnostic and Statistical Manual, Fifth Edition, Text Revision (DSM-5-TR)***—the professionally accepted, single, comprehensive classification system of mental health diagnosis, covering all of the main concerns seen in infancy, childhood, and adolescence, young adulthood, middle adulthood, and later adulthood.
- ***Principal diagnosis***—primary component of the mental health diagnosis, comprising clinical disorders found among the various diagnostic classes of the *DSM-5-TR*.
- ***General medical conditions***—an additional component of a comprehensive mental health diagnosis listing medical and health problems the client is experiencing, especially when relevant to the mental disorders presented.
- ***Psychosocial and environmental stressors***—diagnostic information supporting the principal diagnosis that includes 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 that have identified.
- ***Assessment of functioning***—some manner of competent assessment of the client's adjustment and resiliencies; the person's functioning in important life roles such as academic or occupational or parenting; and the levels of distress, vulnerabilities, symptom severity, and risk being experienced, which ideally is included in each clinically prepared diagnostic formulation or case report (APA, 2022).

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DIAGNOSIS IN THE PROFESSIONAL COUNSELING CONTEXT: *DSM-5-TR* CLASSIFICATION SYSTEM

The earliest European and North American mental health diagnostic systems referred to various forms of "madness" (Rosenberg & Kosslyn, 2014), and the earliest system of diagnosis formally used in the United States included only two classifications: "idiocy" and "lunacy" (APA, 2000). Today, nearly all mental health professionals in the United States rely on the *DSM-5-TR* 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*), 2013 (*DSM-5*), and 2022 *(DSM-5-TR).* 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, 2000, p. xxiii).

The *DSM-5-TR* provides a single, comprehensive system of diagnosis that covers all of the main concerns seen in infancy, childhood, adolescence, young adulthood, middle adulthood, and later adulthood. This means, for example, that concerns ranging from Autistic Spectrum Disorder identified in childhood, through Anxiety, Depressive, and Trauma-Related Disorders experienced in adulthood, to the later life onset of Neurocognitive Disorders due to Alzheimer's disease, all appear together in the *DSM-5-TR*'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 (ADHD), Wanda Maximoff presents an adult occurrence of Prolonged Grief Disorder and Schizoaffective Disorder, and Mama Coco presents late-life onset of Mild Neurocognitive Disorder due to Parkinson's disease.

The *DSM-5-TR* 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 Mama Celie's diagnosis of Persistent Depressive Disorder; on problems of thinking, such as Belle's Social Anxiety Disorder; and on problems with multiple facets, such as Debbie Gallahger's BPD and Jessie's Reactive Attachment Disorder diagnoses.

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

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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-5-TR*'s. Among our pop culture illustrations, for instance, Jamil Malik presents with the immediate concern of Acute Stress Disorder; Mario presents with long-standing problems of Cocaine Use, Alcohol Use, and Gambling Disorders; and Chief Bromden presents with lifelong, entrenched difficulties due to Schizophrenia.

At the same time, although the *DSM-5-TR* 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-5-TR* pertain to these limits and boundaries. They are the system's limited scope and its limited purpose.

SKILL AND LEARNING EXERCISE 2.1

SEARCHING THE *DSM-5-TR*

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-TR*, 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)?

Limited Scope: Definition of a Diagnosable Disorder

A 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-5-TR* 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-5-TR*, 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-TR* 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

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to life events are not diagnosable as psychological disorders. One good example is a person's potential reactions to being the target of adverse discrimination or persecution on the basis of his or her membership in a specific socially constructed category such as "gender or gender identity, race, ethnicity, religion, sexual orientation, country of origin, political beliefs, disability status, caste, social status, weight, [or] physical appearance" (APA, 2022, p. 832). Here, even when those reactions are distressing and problematic, if they are realistic, appropriate, normally expectable responses—meaning they do not cause clinically significant impairment in the person's thoughts, feelings, behaviors and/or physiology—a *DSM-5-TR* mental disorder diagnosis is not justified. Counselors may find it challenging to separate appropriate developmental responses to oppression and discrimination from clinically significant distress or impairment. For example, the emotional distress that Sophia Burset experiences in regards to her gender identity is largely influenced by discriminatory interactions with staff and inmates within the correctional facility as well as limits on Sophia receiving gender-affirming care while incarcerated. Although Sophia meets the criteria for Gender Dysphoria, counselors need to recognize how her environment is significantly influencing her internal emotional state when developing a treatment plan or Sophia.

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, as we suggested above, 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, on one hand, 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. Instead, the *DSM-5-TR* system gives us a way to indicate that our counseling work with a client is focused on "a normal reaction to the death of a loved one" by stating the individual is presenting "Uncomplicated Bereavement" rather than a diagnosable disorder (APA, 2022, p. 834). In our text's popular culture caseload, for example, *West Side Story*'s Maria deals with Uncomplicated Bereavement, which the *DSM-5-TR* classifies as Other Conditions that May Be a Focus of Clinical Attention. On the other hand, if the individual's grief reactions last twelve months or longer, are unusually distressing or impairing, and meet a pattern of more severe life disruption and intense emotional pain, we might consider the person's experience to go beyond what is normally expected and culturally appropriate—and, in turn, we may describe the individual's presentation with the diagnosis of Prolonged Grief Disorder, as in the case of

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Wanda Maximoff. The bottom line is that the *DSM-5-TR* system requires us to make distinctions between the sorts of nondiagnosable life reactions that nearly everyone confronts from time to time, and the less prevalent occurrence of a mental disorder.

Similarly, client thinking and behavior that we view as normally expectable phase-appropriate life-developmental experiences are not diagnosable as psychological disorders even when they cause (nonclincially significant) 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 layoff, divorce, or retirement generally fall into this area as well—as do "starting a new career, becoming a parent, and adjusting to an 'empty nest' after children leave home" (APA, 2022, p. 834) The bottom line in this category is that the *DSM-5-TR* system also requires us to make distinctions between "problem[s] adjusting to a life-cycle transition [or a] particular developmental phase," and the less common life event of developing a mental disorder (APA, 2022, p. 834).

Other Nondiagnosable Behavior. DSM-5-TR 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-TR* criteria for a diagnosable psychological disorder has been met. For instance, as you will read later on in this text's Intersections 3.1, counseling professionals must even distinguish when violent societal behavior is associated with a diagnosable mental disorder and when it isn't. 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 *codependency* or *sex addiction* are commonly used terms in contemporary culture, they are not among the *DSM-5-TR*'s diagnosable disorders. Similarly, while the term, "drug addiction" may be used in other vernaculars to describe "severe problems related to compulsive and habitual use of substances" (APA, 2022, p. 543), this term is not used in the *DSM-5-TR* because its meaning is often uncertain and it has the potential for unintended negative connotations; instead, the *DSM-5-TR* uses the official diagnosis, Substance Use Disorder, to describe the wide range of substance-related difficulties that a client might present.

Specific Purpose: Benefits of a Diagnosis

So far we have described the *DSM-5-TR* 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, which is

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a more chronic type of depressive syndrome, we are provided a great deal of information about the nature of the person's concerns. We know about the primary symptom (depressed mood for most of the day, for more days than not), associated symptoms (disruptions in appetite or sleep, fatigue, low self-esteem or feelings of hopelessness, difficulties with concentration or decision-making, etc.), minimum duration (at least two years), severity of the disruption (the symptoms are causing clinically significant distress, and/or are impairing social, occupational, or other life functioning), and that the client's mood problems are not due to substance use or the side effects of medication—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 Miss Celie's case illustration in chapter 5 of our text.

Importantly, *DSM-5-TR* 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 or 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-TR *are criterion-referenced, and our job is to match up client information with the sets of criteria the* DSM-5-TR *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. This is especially critical in today's world of mental health practice, where "the modern need for professionals across settings and institutions to work together to serve [increasing needs, especially among] marginalized populations is unprecedented" (Schwitzer, 2021, p. 11).

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; social interventions such as environmental adaptations in the community, school, or family; or systemic interventions to remediate neuropsychosocial needs stemming from disparities in health, education, socioeconomics, and other social determinants of wellness (Schwitzer, 2021, p. 11). You will find a good illustration of this by reading the diagnostic impressions, case conceptualizations, and treatment plans we present in Debbie Gallagher's case report in chapter 5 of the text.

In addition, when the information is known, the *DSM-5-TR* provides data for each diagnosis pertaining to primary diagnostic features and associated features supporting the diagnosis;

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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 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.

FIGURE 2.1 ■ *DSM-5-TR* 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-TR* criteria Patterns described by colloquial definitions but not meeting any specific *DSM-5-TR* 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

Counselor Reservations About Diagnosis

Along with the benefits of diagnosis, important counselor reservations have been raised about the use of the *DSM-5-TR* 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-TR*'s limit of scope. We also have

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addressed the misperception that the system determines the theoretical or disciplinary approach of the case conceptualization and treatment plan by discussing the *DSM-5-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-5-TR* 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 et al., 2005). This concern is a substantive one; after all, along historical lines, African Americans, for example, have encountered misdiagnosis, mistreatment or lack of treatment, manipulation of health data, and other negative consequences of entrenched marginalization across the generations in their interactions with the American scientific and medical communities (Washinton, 2006). Looking at this question empirically and in the modern context, researchers have reported that African American clients with mood disorders are likely to be misdiagnosed with Schizophrenic Disorders (Neighbors et al., 2003; Schwartz et al., 2019; Trierweiler et al., 2005), while Latinx clients may tend to have their presenting concerns underdiagnosed by their counselors (LaBruzza & Mendez-Villarrubia, 1994; Schmaling & Hernandez, 2005). Further, African American and Latinx youth are more likely to be diagnosed with disruptive behavioral disorders such as Oppositional Defiant Disorder (ODD) and Conduct Disorders, as compared to non-Hispanic White youth who are more likely to receive a diagnosis of ADHD (Fadus et al., 2020).

In response, the *DSM-5-TR*'s authors attempt to address issues of gender and multiculturalism in several ways. The text outlines how these themes are to be addressed in today's clinical contexts under its "Cultural and Social Structural Issues" section, which addresses "Cultural Concepts of Distress," "Impact of Racism and Discrimination on Psychiatric Diagnosis," "Attention to Culture, Racism, and Discrimination in *DSM-5-TR*," and "Sex and Gender Differences" (APA, 2022, pp. 16-19). Following these, each diagnosis includes contextual information, when it is known, under the separate heading, "Culture-Related Diagnostic Issues" and "Gender-Related Diagnostic Issues." For instance, when we are considering a diagnosis of Major Depressive Disorder, the *DSM-5-TR* confirms for us that although "there is substantial cross-cultural variation … major depressive disorder can be identified across diverse cultural contexts" (APA, 2022; p. 189). The *DSM-5-TR* goes on to indicate that, across cultures, there is a wide range of complaints reflective of major depression, some of which do not comply with the conventionally listed symptom criteria and that counseling professionals must remember, therefore, that "[u]nderstading the significance of these symptoms requires exploring their meaning in local social contexts" (APA, 2022, p. 190). *DSM-5-TR* additionally provides a detailed roadmap under its "Outline for Cultural Formulation" and "Cultural Formulation Interview (CFI)" to assist practitioners in this type of social contextual exploration (APA, 2022, pp. 861-862). Age differences in the prominent features of many diagnoses are presented. For instance, continuing with our illustration, variations in prominent Major Depression features include failure to gain expected weight among children

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and irritable mood among children and adolescents. In fact, for Posttraumatic Stress Disorder (PTSD), an entirely separate list of criteria is devoted to clients under the age of six years.

The *DSM-5-TR*'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-5-TR* 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 and Anxiety Disorders appear to be diagnosed more commonly among women, and Obsessive-Compulsive Disorder (OCD) 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-5-TR*.

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 Sophia Burset, 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, mental health professionals must fill a social justice role associated with access to appropriate services by taking the lead in countering perceived potential negative effects of diagnosis. Counselors must be vigilant in correcting the common misperception that clinical diagnosis classifies or labels people; instead, the *DSM-5-TR* really classifies the psychological disorders people are experiencing. To promote this, the *DSM-5-TR* is written in a way that encourages clinicians to carefully use 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, 2022). 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 Mario as a person with substance use concerns rather than as a drug addict or 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

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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 "Ego-dystonic 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 (LGB) sexual orientation. The change in viewpoint was based on the corrected finding that having a nonheterosexual sexual identity per se did not constitute a mental health diagnosis, in addition to the recognition that psychiatric and medical systems were contributing to the societal stigmatization of LGB identities (Drescher, 2015). Distress experienced by LGB individuals is often related to societal homophobia rather than. 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, 2000, p. 582) might be used to best describe a client's primary concerns. Beginning with *DSM-5* continuing with *DSM-5-TR*, 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 "sex education, sexual behavior, sexual orientation, sexual attitudes (embarrassment, timidity), others' sexual behavior or orientation (e.g., spouse, partner, child), sexual enjoyment, or any other sex-related issue" (APA, 2022, p. 834).

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 as it operates in the United States 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, certain 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-TR*, 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 sound clinical judgment. The *DSM-5-TR* warns in its narrative that "excessively flexible and idiosyncratic application of the *DSM-5-TR* criteria" undermines and weakens it as a clinical thinking tool (APA, 2022, p. 23). In our own case illustrations and throughout this textbook, 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.

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Additional Thoughts. We now have introduced the *DSM-5-TR* 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 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-5-TR* and foundational 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 *Encanto's* Bruno (Case 5.10) 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-TR* 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 diagnoses of OCD was decided upon to describe Bruno's presentation. What characteristics of Bruno's presenting concerns fall within the scope of the *DSM-5-TR* and allow the diagnosis of a psychological disorder? What symptoms does Bruno present that correspond with Anxiety Disorders? With Obssessive-Compulsive Disorders? What other categories of disorders may you consider for diagnosing when reading his case summary? What specific criteria were needed for the diagnosis of OCD? How did the counselor conceptualize Bruno's symptoms within his Latinx cultural context?

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 Brunos's symptoms were described by OCD? What could you infer about the types of symptoms he was experiencing? The types of life events he had experienced? About the time frame of his difficulties?

In this chapter, we discussed common counselor reservations about *DSM-5-TR* diagnoses, including criticisms related to social-cultural considerations. How are they relevant to Bruno's situation? How did Bruno'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 Bruno? Do you believe there are disadvantages, and if so, what are they?

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

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DSM-5-TR DIAGNOSTIC SYSTEM

We said in chapter 1 of our text that a *DSM-5-TR* 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-TR* text itself, on pages 21-26, so that as long as you have your copy of the *DSM-5-TR* 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.

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	Another medical problem and other health problems when relevant
Psychosocial and environmental stressors	Relevant psychosocial and environmental stressors, problems, and contexts
Assessment of functioning	Clinical estimates of overall distress or functioning

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-TR.*

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. The *DSM-5-TR* system considers these to be another medical condition, or other medical condition, beyond the mental disorder diagnosis.

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, social systemic, or other life stressors or pressures the client

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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 of clinical estimate. The *DSM-5-TR* itself presents a discussion of state-of-the-art assessment approaches on pages 841-857.

SKILL AND LEARNING EXERCISE 2.3

UNDERSTANDING THE *DSM-5-TR* 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 (Case 5.3), 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.

By examining clinical disorders, you will see we first recorded Eleanor Rigby's mood problem, Depressive Disorder due to hypothyroidism, according to *DSM-5-TR* 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-TR* diagnostic system. Counseling professionals use the approximately three hundred individual diagnoses contained in the *DSM-5-TR* to answer questions such as the following:

> "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

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

The Clinical Disorders: Interchapter Organization

The long list of diagnosable mental disorders is divided into twenty 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* -5-TR 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, PTSD, 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—his or her thoughts, feelings, behaviors, or physiological signs—seem primarily suggestive of panic, a phobia, or social anxiety (found under Anxiety Disorders); troubles with falling asleep, maintaining sleep, and being rested (found under Sleep Disorders); or possibly sexual performance (found under 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 [twenty] diagnostic classes (or chapters) to just a few possibilities?" (LaBruzza & Mendez-Villarrubia, 1994; p. 86).

Further, the *DSM-5-TR* text is organized from front cover to back cover in a way that is intended to help us answer this question. Take another look at the order of the classes of disorders appearing on pages xxvii–lxi of the *DSM-5-TR.* You will discover that 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. 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. Further, generally speaking, the *DSM-5-TR* is organized along developmental lines. That is, from the front cover to back cover, you will find near the beginning those diagnoses that

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manifest early on in life (the often Neurodevelopmental and Schizophrenic Disorders), you will see following these there are diagnoses often seen in adolescence and earlier adulthood (like the Bipolar, Depressive, and Anxiety Disorders), and then you will locate disorders common to late adult life (such as the Neurocognitive Disorders) near the end. Specifically, as you thumb through the *DSM-5-TR*, you will encounter the following contents:

First Considerations: Neurodevelopmental Disorders and Schizophrenia Spectrum Disorders

According to the *DSM-5-TR*'s interchapter design, the first two chapters to appear both address disruptions in thought and communication. The first of these presents those disorders experienced earliest in the life span, and the second chapter presents those disorders experienced soon after. Both chapters warrant the counselor's very close 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 Development Disorders, Communication Disorders, Autism Spectrum Disorder, ADHD, Specific Learning Disorder, Motor Disorders, and Other Neurodevelopmental Disorders.

Child therapists, family clinicians, school counselors, and others who work extensively with individuals under age eighteen years rely heavily on this chapter. Of particular note, school counselors and their clinical colleagues with child and adolescent caseloads often find the Autism Spectrum Disorders, ADHD, and the Specific Learning Disorders (with impairment in reading, written expression, and/or mathematics), to be especially important to their diagnostic work.

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 ADHD (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-TR* pages 35-37.

Diagnostic Advances. We wrote earlier in this chapter about the need for ongoing efforts to keep the *DSM* up-to-date in ways that are accurate responses to evidence-based clinical advances, compelling social advances, and advances in clinical practice demands. You can see examples of these responses under the *DSM-5-TR* Neurodevelopmental Disorders. Looking at social advances, *DSM-5-TR* now uses the term, "Intellectual Developmental Disorder," in order to be consistent with modern language and to be consistent with the vocabulary of the World Health Organization's (WHO) *International Classification of Diseases (ICD-11)*. *DSM-5-TR* does continue to include the more outdated phrase, "Intellectual Disability" in parentheses to avoid any clinical confusion at this point; however, going forward, Intellectual Developmental Disorder

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will be the term of choice to avoid stigmatization and to be professionally consistent. As both a social and clinical advance, Intellectual Developmental Disorder's "Diagnostic Features" section now better alerts clinicians to be careful when applying IQ scores and to avoid being too narrowly bound by them. Likewise, the Autism Spectrum Disorder criteria were strengthened so that, for example, deficits in social-emotional reciprocity, deficits in nonverbal communication, and relationship deficits *all* are required for the diagnosis; this change raises the threshold for the diagnosis so that the intent of the diagnosis is clear and there is no mistake about the behavioral impairments a counseling professional must find in a client in order to apply this spectrum of disorders. This should help with problems related to overuse or misuse of the Autism Spectrum Disorders due to culture, racism, payment pressures, or any other non-evidence-based source of error.

SKILL AND LEARNING EXERCISE 2.4

BECOMING FAMILIAR WITH NEURODEVELOPMENTAL DISORDERS

Diagnoses relying on the developmental disorders affecting thought, communication, and behavior are represented in our cases of Naruto (Case 5.4) and Christopher Robin (5.12), found in chapter 5.

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

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 Schizophrenia 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

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word "spectrum": Delusional Disorder, in which the client vehemently holds nonbizarre but untrue beliefs in areas of romance, grandiosity, jealousy, persecution, and so on; Brief Psychotic Disorder, where an individual experiences psychotic disturbances (delusions, hallucinations, etc.) for more than a day but less than a month before returning to normally expected levels of functioning; 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 six 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 manic or major depressive episode are troubling the client or patient. The chapter also contains diagnoses for other disturbing psychotic and delusional problems, including Schizotypal Personality Disorder, Schizophreniform Disorder, and others. Clinicians in medical, psychiatric, and other settings in which these types of symptoms appear may have expertise especially with this red flag chapter. A summary of the cardinal features of Schizophrenia Spectrum and Other Psychotic Disorders appears on *DSM-5-TR* pages 101-104. Interestingly, because the symptoms of Schizotypal Personality Disorder are frequently associated with Schizophrenia, this disorder is colisted in the chapter Schizophrenia Spectrum and Other Psychotic Disorders.

Diagnostic Advances. As you will learn during your studies of the *DSM-5-TR*, each class of disorders includes an alternative for "other disorders" to give clinicians the most descriptive power possible as they work through their diagnostic decision-making process with each unique client. In this chapter, Other Specified Schizophrenia Spectrum and Other Psychotic Disorder is used to capture situations in which a Schizophrenia Spectrum or Other Psychotic Disorder is causing clinically significant distress or in impairment in important areas of functioning, but these symptoms do not meet the full criteria for any one of the disorders in the chapter. In *DSM-5-TR,* as a clinical advance, the helpful examples of scenarios in which the other disorders category might be used have been tightened up to be sure the use of Other Specified Schizophrenia Spectrum and Other Psychotic Disorder is as clear and accurate as possible (you can read about the use of this diagnosis on page 138 of the *DSM-5-TR*).

BECOMING FAMILIAR WITH SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

The Schizophrenia Spectrum Disorders are represented in our cases of Chief Bromden's symptoms of Schizophrenia, (Case 5.16) and Wanda Maximoff's symptoms of Schizoaffective Disorder (Case 5.7). To increase your understanding of diagnostic decision-making with Neurodevelopmental Disorders, take time now to closely read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in these cases. Refer to your copy of *DSM-5-TR* as you study the diagnostic aspects of each case illustration.

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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-TR* 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 Latinx 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-5-TR*. 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-TR* 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 (APA, 2022; 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-5-TR* diagnosis criteria sets (note that Substance-Related and Addictive Disorders also are common, but the various classes of disorders associated with mood and anxiety stand out for their prevalence).

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Bipolar and Related Disorders

This chapter includes diagnosable syndromes characterized by elevated or irritable mood and the potential for depressed mood (APA, 2022; Federman & Thomson, 2010). 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, 2022; Federman & Thomson, 2010). 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-TR* page 139; however, to really see how these important disorders function, you might initially gain an overview by reading through pages 139-143, 150-153, and 159-160.

Diagnostic Advances. Because the *DSM-5-TR* is a criterion-referenced system, and therefore the counseling professional's task is to find the best descriptive match between the client or patient's presenting symptoms and the various sets of diagnostic criteria offered in the *DSM-5-TR*, the concept of differential diagnosis is critically important to our clinical thinking. As you can see in any of our chapter 5 case examples, differential diagnosis deals with "how to differentiate [a disorder under consideration] from other disorders that have some similar presenting characteristics" (APA, 2022, p. 27). In this context, there are symptom features that Bipolar Disorders share with Schizophrenia, Schizoaffective Disorder, and perhaps other mood and Psychotic Disorders. As a clinical advance, *DSM-5-TR* makes the decisions in this regard easier to follow. The criteria for Bipolar I now tell us, "At least one manic episode is not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other … psychotic disorder" (p. 142). Likewise, for Bipolar II, "At least one hypomanic episode and at least one major depressive episode are not better explained by schizoaffective disorder and is not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, or other … psychotic disorder" (p. 152). These types of details might seem difficult to master at this early point in your introduction to diagnosis; however, at some later point in your *DSM-5-TR* studies, when concentrating on the Bipolar Disorders, you will see how important this advance in differential diagnosis guidance is!

The *DSM-5-TR* system also includes *specifiers* and *severity specifiers* to allow clinicians to tailor each diagnosis as closely as possible to the experiences of a specific client. *DSM-5-TR* also advances clinical thinking by fine-tuning the Mood-Congruent/Mood Incongruent Psychotic Features Specifier and the Severity Specifiers for the Bipolar Disorders. You can learn about these specifiers by closely studying the material found in the chapters for the two classes of disorders, Bipolar and Related Disorders, and Depressive Disorders.

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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, 2022, p. 177), where mood is defined as "a pervasive and sustained emotion that colors the person's perception of world" (APA, 2000, p. 825). 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 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.

You should carefully read *DSM-5-TR* page 177 for a summary of the Depressive Disorders.

Diagnostic Advances. We saw above, with the Bipolar Disorders, how important differential diagnosis is to the diagnostic process. As with the Bipolar Disorders, Depressive Disorder symptomatology may overlap with some of the Psychotic Disorders—so that, for example, sometimes the client's needs are better described by Schizoaffective Disorder than by a Depressive Disorder or, at other times for example, a Major Depressive Disorder might co-occur with Schizophrenia or Delusional Disorder. As a clinical advance like the ones for the Bipolar Disorders, *DSM-5-TR* makes these decisions easier to follow. Take a look at the Depressive Disorders chapter in your *DSM-5-TR* to get a better idea of when a Psychotic Disorder *excludes* a Major Depressive Disorder and, alternatively, when the Depressive Disorder might be *superimposed* on the client's psychotic disorder. This is a fascinating area of differential diagnosis that you will encounter as your professional development progresses.

As another diagnostic advance, the *DSM-5-TR* Bipolar Disorders and Depressive Disorders now include Unspecified Mood Disorder to describe a clinical situation in which the professional has identified mood-related symptoms that are causing the client or patient clinically significant distress or impairment in important areas of functioning, but where the symptoms do not meet the complete criteria for any of the syndromes in the Depressive Disorders class, Adjustment Disorder with depressed mood, or Adjustment Disorder with mixed anxiety and depressed mood. As you will be learning, this is a powerful diagnostic option because it can be used when you are not ready to specify the reason that the criteria for those competing diagnosing are not met and when there is not enough information to be more specific—like on a crisis counseling response or in emergency department settings (APA, 2022).

Also in this class of disorders, as a sort of social and clinical advance, antiquated terms like the outdated "dysthymia" and unnecessary specifiers have been eliminated. This will be an advantage as you engage in learning about this crucial class of disorders.

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Anxiety Disorders

Similar to the chapters on Bipolar and Depressive Disorders, this important class of disorders 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, 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.

At this point, you might carefully review *DSM-5-TR* pages 215-216 for a summary of the Anxiety Disorders.

Diagnostic Advances. Just like we saw with the Depressive Disorders, one diagnostic advance in the Anxiety Disorders chapter is that the outmoded term *social phobia* has been removed from the system's discussion of Social Anxiety Disorder. Earlier in this chapter, we said the modern *DSM-5-TR* approach is designed to be theory-neutral; antiquated terms like social phobia fall by the wayside when they no longer have any ongoing clinical utility.

Obsessive-Compulsive and Related Disorders

This chapters presents a class of disorders 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, and unwanted (for example, unwanted thoughts and images), as well as on "compulsions" that are repetitive behaviors or mental acts the client feels urged or compelled to undertake, sometimes in response to unwanted obsessive thinking (APA, 2022, p. 263). Included are OCD (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 Disorder (featuring the perceived need to exhaustively save possessions), and Trichotillamania and Excoriation Disorder (hair-pulling and skin-picking disorders, respectively). The chapter is rounded out by other related obsessive-compulsive syndromes. Here again, we refer you to carefully read *DSM-5-TR* pages 263-265 for a good summary of the Obsessive-Compulsive and Related Disorders.

Diagnostic Advances. *DSM-5* and now *DSM-5-TR* stand out for their treatment of the Obessive-Compulsive Disorders. As a major clinical advance, based on increasing evidence distinguishing the obsessive thoughts and repetitive behaviors of the Obsessive-Compulsive-Related Disorders from anxiety alone, the Obsessive-Compulsive Disorders today warrant their own class of disorders in the modern taxonomy. Whereas historically these syndromes were subsumed under the Anxiety Disorders, this separation of the Obsessive-Compulsive Disorders into a diagnostic class that is distinct from Anxiety Disorders improves the clarity with which we can evaluate and describe client needs in this clinical area (Browne et al., 2015).

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Trauma- and Stressor-Related Disorders

The diagnoses comprising this class of disorders 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 presents 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 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-5-TR* definition of trauma, all of which are explained inside the chapter—and Adjustment Disorders, which, by definition, comprise "the development of emotional or behavioral symptoms in response to an identifiable stressor" (APA, 2022, p. 319). 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. Criteria sets for Other Specified Trauma- and Stressor-Related Disorder and for Unspecified Trauma- and Stressor-Related Disorder also appear. We recommend you read the short summary on *DSM-5-TR* page 295 and also closely review the chapter's discussions of differential diagnosis as it pertains to PTSD, Acute Stress Disorder, Adjustment Disorder, Other Specified and Unspecified Trauma- and Stressor-Related Disorder.

Finally among the *DSM-5-TR* trauma and stressor disorders is Prolonged Grief Disorder. This clinical presentation is characterized as a "persistent grief reaction" of at least twelve months of bereavement in adults or at least six months in children and adolescents—featuring intense yearning or longing for the deceased, intense sorrow and emotional pain, and preoccupation with thoughts and memories related to the deceased or the circumstances of the death that cause clinically significant distress or impairment in social, occupational, or other important areas of everyday functioning (APA, 2022, p. 323).

Diagnostic Advances. The inclusion of Prolonged Grief Disorder is, in fact, the most important diagnostic advance among the Trauma- and Stressor-Related Disorders. It is a brand-new entry among the *DSM-5-TR* syndromes, taking its place in *DSM-5-TR* following extensive research (previously it was treated in the *DSM* system as a "condition for further study"). Making the diagnosis can be important, since it is associated with work or school or social impairment, withdrawal from relationships, harmful health behaviors or increases in serious medical conditions, developmental consequences in children and adolescents, and the like (APA, 2022). At the same time, a key requirement when accurately making the Prolonged Grief Disorder diagnosis is to distinguish the disorder from normally expected, uncomplicated grief. Importantly, "the

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duration and severity of the bereavement [must] clearly exceed expected social, cultural, or religious norms for the individual's culture and context" (p. 323).

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 twenties 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 two 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 with Depressed Mood (see *DSM-5-TR* pages 183-184 & 319-320 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-TR* 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 reread the intake summary, diagnostic impressions, and diagnostic discussion found in the case of Billie Jean (Case 5.2) and in the case of Debbie Gallagher

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(Case 5.6), in which we differentiate between the symptoms of Bipolar Disorders and BPD. To increase your understanding of diagnostic decision-making with Depressive Disorders, take time now to closely read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in the cases of Eleanor Rigby (Case 5.3), Data (Case 5.17), and Miss Celie (Case 5.20). To increase your understanding of diagnostic decision-making with Anxiety Disorders, read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in Belle's case (Case 5.8). Bruno's case (Case 5.10) represents a presentation of Obsessive-Compulsive Disorders, while Elphaba's (Case 5.15) and Claire's (Case 5.13) case demonstrates additional diagnostic decision-making with Obssessive-Compulsive Disorders. To increase your understanding of diagnostic decision-making with Trauma- and Stressor-Related Disorders, closely read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in the cases of Wanda Maximoff (Case 5.7), Jamil Malik (Case 5.1), Jessie, Maria (Case 5.5), and Miss Celie (Case 5.20).

It will be helpful to have your copy of the *DSM-5-TR* 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-TR* 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 bipolar mood problems or depressive mood, anxiety or obsessive-compulsiveness, and/or trauma- or stressor related syndromes 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, emotion, perception, body representation, motor control, or behavior. The term *dissociation* itself, which is central to these classes of disorders, refers to "unbidden intrusions into awareness and behavior, with accompanying losses of continuity in subjective experience … and/or inability to access information or to control mental functions that normally are readily amendable to access or control" (APA, 2022, p. 329). These disorders are summarized on *DSM-5-TR* pages 329-330.
- ***Somatic Symptom and Related Disorders,*** which share as a common feature the presence of prominent somatic (physical) symptoms and/or illness anxiety leading to clinically significant distress or impairment. A summary is found on *DSM-5-TR* pages 349-351. Examples from this class of disorders—which are especially common among primary care and other medical settings—include the following: Illness Anxiety Disorder, featuring distressing or impairing preoccupation with having or acquiring

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an illness, and Somatic Symptom Disorder, featuring the presence of physical medical symptoms that result in clinically important psychological distress or significant impairment in daily life functioning.

- ***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, Other Specified Eating Disorder, and Unspecified Feeding or Eating Disorder. See *DSM-5-TR* page 371 for a short summary, and then review the differential diagnoses sections found in the chapter for comparisons of Anorexia Nervosa, Bulimia Nervosa, Binge-Eating Disorder, Other Specified Eating Disorders, and Unspecified 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) and Encopresis (passage of feces in inappropriate places), as well as Other Specified Elimination Disorder and Unspecified Elimination Disorder.
- ***Sleep-Wake Disorders,*** all of which share characteristic complaints regarding sleep-wake behavior, including problems with the quality, timing, and amount of sleep. As a core feature, all of these Sleep-Wake Disorders result in clinically significant daytime distress or impairment. Insomnia Disorder, Hypersomnolence Disorder, Breathing-Related Sleep Disorders, and Nightmare Disorder are examples. You can see *DSM-5-TR* pages 407-409 for a summary of these disorders, definitions of terms, and discussions of their relationship with suicidality and with other mental disorders.
- ***Sexual Dysfunctions,*** all of which are characterized by clinically 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 prominent examples. The diagnosable sexual dysfunctions are summarized on *DSM-5-TR* pages 477-478.
- ***Gender Dysphoria,*** a *DSM-5-TR* diagnostic class presenting the single diagnosis of Gender Dysphoria, which captures clinically significant incongruence between the individual's experienced or expressed gender and the biological or assigned gender at birth, either in children (Gender Dysphoria in Children) or in adolescents or adults (Gender Dysphoria in Adolescents and Adults). See *DSM-5-TR* pages 511-512 for a detailed description.

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- ***Disruptive, Impulse-Control, and Conduct Disorders,*** which present diagnosable conditions centering on problems with behavioral and emotional self-control—including ODD (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 eighteen years might rely heavily on some of the diagnoses in this chapter. You should see the summary found on *DSM-5-TR* pages 521-522 and review the various differential diagnosis sections throughout the chapter for a comparison of ODD, 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, 2022, p. 537), this disorder is colisted in the chapter of Disruptive, Impulse Control, and Conduct Disorders.
- ***Substance-Related and Addictive Disorders,*** an expansive 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; Substance-Induced Sleep Disorders and Sexual Dysfunctions; as well as Substance-Induced Delirium and Neurocognitive Disorders. Substances included in the chapter comprise alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, dedatives, stimulants, tobacco, and other or unknown. Also appearing is the "non-substance-related addictive disorder": Gambling Disorder, 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 prevalent 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-TR* page 545 and a chapter summary on pages 543-544.
- ***Neurocognitive Disorders,*** a class of disorders all referring to prominent clinical disturbances that must be due to (a) a specific, physiological or 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 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

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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 important 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-TR* pages 670-671 and a chapter summary on pages 667-668.

- ***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. The *DSM-5-TR* presents an alternative model for Personality Disorders with the "aim to address shortcomings of the approach in Section II to personality disorders" (APA, 2022, p. 881). The alternative criteria presented in pages 881 to 901 may assist you with understanding the pattern of symptoms, self/interpersonal functioning, and personality traits that correspond with six of the ten specific Personality Disorder diagnoses.
- ***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. They include preferences for anomalous sexual activities along with preferences for anomalous sexual targets. Two examples that stand out 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). Likewise, the problems of 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-TR* pages 779-780 for a full summary).
- ***Other Mental Disorders and Additional Codes,*** 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-TR* classes of disorders. The 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; and Unspecified Mental Disorder—plus No Diagnosis or Condition, where "the person has been evaluated and it is determined that no mental disorder or condition is present" (APA, 2022, p. 805). See *DSM-5-TR* pages 803-805.

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Diagnostic Advances. With each new revision to the *DSM* system, a variety of relatively minute, technical advances are made to the classes of disorders with shared phenomenological features. These mostly take the form of clinical editing and fine-tuning to repair formerly unclear language and to ensure the diagnostic criteria reflect their intended meaning as carefully as possible for the professionals who use them. These sorts of editorial house-keeping improvements do not warrant much discussion here; as always, counseling professionals who are meticulous, conscientious readers and closely follow the text will competently apply the clinical thinking tool of *DSM-5-TR* diagnosis to their practice. Occasionally, though, a more notable change occurs. Among the *DSM-5-TR's* clinical advances to the classes of disorders with shared phenomenologies, for instance, under the Feeding and Eating Disorders, in the chapter's discussion of atypical anorexia, where all of the criteria for anorexia are met except that despite drastic weight loss the person's weight remains within the normal range, the following sentence was added in order to assist clinicians in their differential diagnosis process: "Individuals with atypical anorexia nervosa [still] may experience many of the physiological complications associated with anorexia" (APA, 2022, p. 396). Turning to an illustration of the *DSM-5-TR's* social advances, under the Gender Dysphoria class of disorders, vocabulary was updated to better reflect culturally sensitive language: The *DSM-5-TR* now uses the phrases *experienced gender* (replacing the outmoded *desired gender*), *gender-affirming medical procedure* and *gender-affirming hormone treatment* (replacing the outmoded *cross-sex medical procedure* or *cross-sex hormone treatment*), *individual assigned male at birth* and *individual assigned female at birth* (replacing the outmoded *natal male* or *natal female*), and *differences in sex development* (as an alternative to *disorders of sex development).*

SKILL AND LEARNING EXERCISE 2.6

BECOMING FAMILIAR WITH SEVERAL DIAGNOSTIC CLASSES OF DISORDERS

Several of these classes of diagnosis are represented in our popular culture caseload found in chapter 5. We recommend that you closely read several of the *DSM-5-TR* 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 Sleep-Wake Disorders and Substance Use and Addictive Disorders, take time now to closely read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in the case illustration of Mario (Case 5.19). To further enhance your understanding of Sleep-Wake Disorders along with Gender Dysphoria, refer to the case of Sophia Burset (Case 5.9). The case of Claire (Case 5.13) demonstrates diagnostic-decision making across three classes of disorders: Substance Use and Addictive Disorders, Feeding and Eating Disorders, and Obsessive-Compulsive Disorders. To increase your understanding of diagnostic decision-making with Neurocognitive Disorders, take time now to closely read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in the case illustration of Mama Coco (Case 5.11).

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

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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 a 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-TR*]?" (LaBruzza & 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 [ACA], 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, 2022, p, 733)

Note that as with other diagnosable mental disorders, the *DSM-5-TR* 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-TR* contains twelve different diagnosable Personality Disorders. They all appear together in one chapter. You can find them summarized on *DSM-5-TR* pages 733-734. The *DSM-5-TR* also provides an instructive general personality disorder criteria template on pages 754-755.

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For our convenience—to help us work our way through this class of diagnoses—the Personality Disorders are divided up in the *DSM-5-TR* into three categories based on descriptive similarities among the Personality Disorder diagnoses. The *DSM-5-TR* 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 suspicion. 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 (BPD) 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.

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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 ten specific disorders outlined earlier, the *DSM-5-TR* 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.

Additional Note about the DSM-5-TR's Alternative Model for Personality Disorders. 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-TR* Personality Disorders Task Force has continued the field's empirically-based study of Personality Disorders by dimensions. The *DSM-5-TR* result of this ongoing clinical research is a supplementary discussion appearing in Section III of the text that offers a suggestive "Alternative *DSM-5* Model for Personality Disorders." This alternative model is a "hybrid dimensional-categorical model" which defines Personality Disorder partly in terms of impairments in personality functioning and partly in terms of pathological personality traits (APA, 2022, p. 881). This alternative model may be of interest to some learners for whom a deeper consideration of personality, its function, and it dysfunction may be professionally enticing. We encourage you to take a look (*DSM-5-TR* pages 901); however, to be clear, the currently used diagnostic scheme of Personality Disorders appears inside *DSM-5-TR's* Sectoin II: "Diagnostic Criteria and Codes."

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FIGURE 2.3 ■ *DSM-5-TR* Helpful Interchapter Organization

A

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 distress related to a marked incongruence between experienced/expressed gender and assigned gender

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FIGURE 2.3 ■ *DSM-5-TR* Helpful Interchapter Organization (*Continued*)

B

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 to 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-TR* diagnosis

Source: Dailey, S. F., Gill, C. S., Karl, S. L., & Bario Minton, C. A. (2014). DSM-5: *Learning companion for counselors.* Alexandria, VA: American Counseling Association.

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-5-TR* Personality Disorders, found in the text's Section II, 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 this section, take time now to closely read or reread the intake summary, diagnostic impressions, and diagnostic discussion found in the cases of Debbie Gallagher (Case 5.6), Elphaba (Case 5.15), and Belle (Case 5.8). It will be helpful to have your copy of the *DSM-5-TR* available as you study the diagnostic aspects of these case illustrations.

THE CLINICAL DISORDERS: INTRACHAPTER ORGANIZATION—WHAT'S INSIDE EACH CHAPTER?

We said earlier in this chapter that it is important to learn about two aspects of the *DSM-5-TR* 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 essential because once the

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counselor has tentatively narrowed 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-5-TR* 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 all, or most, of the following elements provided for each of the diagnoses in each clinical disorder chapter: Diagnostic Criteria, Specifiers and Subtypes, and Coding and Recording Procedures (all appearing in a stand-alone box that forms the centerpiece of each disorder); Diagnostic Features; Associated Features; Prevalence; Development and Course; Risk and Prognostic Factors; Culture-Related Diagnostic Issues; Sex- and Gender-Related Issues; Association with Suicidal Thoughts or Behavior; Functional Consequences; Differential Diagnosis; and Comorbidity.

Diagnostic Criteria and Diagnostic Features. The *DSM-5-TR* discussion of every 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 six 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, specifiers and subtypes, differential diagnoses, recording procedures—and all of the relevant information is currently available about, for instance, culture-related or sex- and gender-related diagnostic issues, functional consequences including suicidal thoughts or behavior, as well as the important differential diagnoses and comorbidity.

Specifiers and Subtypes. Specifiers and subtypes are used to increase the descriptive power of our diagnoses. In formal terms, specifiers and subtypes "delineate phenomenological variants of a disorder indicative of specific subgroupings" (Regier et al., 2013; p. 96). This means the specifiers including subtypes assist us to more closely match a diagnosis with an individual client's presentation so that the diagnosis very carefully describes the exact dimensions of

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the mental health problem being uniquely experienced. Because, as we are learning, all three of the clinical thinking tools work together, doing a good job not only with the primary diagnosis but also with decisions about specifiers including subtypes can positively affect our work later with conceptualizing and planning for treatment (Regier et al., 2013). 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 is currently experiencing only some symptoms. 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 (or just a few symptoms), it might be clinically useful to use this specifier to indicate that although the person is currently experiencing no or few symptoms, their previous symptoms indicated a fully disruptive manic episode. 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, "in early remission" or "in sustained remission," indicating whether the person has been free of substance dependence for less than or longer than twelve 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 OCD, we may indicate the degree to which the individual recognizes his or her obsessive-compulsive beliefs are irrational or untrue, by including specifiers for "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 and jointly exhaustive phenomenological subgroupings within a diagnosis" (APA, 2022, p. 22). 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).

As we have said, 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. You probably have noticed that *DSM-5-TR* diagnoses include an alphanumeric code preceding the name of the disorder (or preceding a coded subtype

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or specifier). The coding is essential to maintaining health and mental health records—but there really is no need to memorize or overly focus your learning on these since the codes will always be available to you for reference right in the *DSM-5-TR*. Those codes you have noticed are taken from the *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)*. They represent a version of the WHO's *ICD-10-CM* that has been clinically modified for use in the United States by the National Center for Health Statistics (NCHS). These codes give us a sort of abbreviation for reporting diagnoses, and this system is the only permissible official coding system currently used in the United States. You will find recording procedures and coding notes, as needed, throughout the *DSM-5-TR*. 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-TR/ICD-10-CM* 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-TR* 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:

- F32.1 Major Depressive Disorder, Single episode, Moderate.

Associated Features. Once the main diagnostic criteria and features have been explained and the instructions provided for recording the diagnosis, next the *DSM-5-TR* 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. They help support our diagnostic decision-making. More specifically, associated presentations are "clinical features that are not represented in the criteria, but occur significantly more often in individuals with the disorder than those without the disorder" (APA, 2022, p. 26). For example, under the class of Feeding and Eating Disorders, the Associated Features 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. Once again, although this information is valuable, associated features are not actually part of the diagnostic criteria for the disorder with which they are connected.

Prevalence. When information about prevalence is known for a diagnosis, it is provided. Whenever possible, prevalence is described based on a twelve-month occurrence in the general community; however, you might find instead prevalence rates for relevant clinical or counseling populations. The Prevalence section also gives us prevalence estimates, when they are known, according to age groups, "ethnoracial/cultural" groups, and sex ratio (prevalence by conventional dichotomous gender distinctions of women and men) (APA, 2022, p. 26). Sometimes

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you will also find international or other geographic comparisons of prevalence. For instance, by reviewing the prevalence information for Schizoaffective Disorder, we learn that this very disruptive disorder is "one-third as common as schizophrenia," with a lifetime prevalence of just 0.3 percent in one study that used a Finnish population. We also are alerted to data showing the disorder's prevalence to be "higher in women than in men" (APA, 2022, p. 123). Understanding the dynamics of lifetime onset, prevalence, and related factors can be crucial to improving the accuracy with which we employ our clinical thinking (Kessler et al., 2005).

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. When the data are available, this can include typical age of onset or usual life developmental stage, lifetime patterns and evolution, whether there is usually a prodromal lead-up or build-up in symptoms or a more abrupt onset, whether symptoms tend to occur as a persistent ongoing course or in episodes, progression of severity over time (that is, whether the problems tend to be stable, worsening, or improving over the disorder's duration), and other features describing clients' and patients' usual experience the disorder by development or course. Here again, understanding such dynamic factors can improve the accuracy of our clinical judgment (Kessler et al., 2005).

Risk and Prognostic Factors. Each *DSM-5-TR* diagnosis text discussion also may include information about the risks or vulnerabilities associated with a disorder, the prognosis, or the risk level for harm, where applicable. These factors may comprise personality and other intrapersonal features ("temperamental factors"); experiences such as physical or emotional trauma, substance use or toxic exposure, etc. ("environmental factors"); or genetic or familial or epigenetic risks ("genetic and physiological factors") (APA, 2022, pp. 26-27). As you can see, understanding these factors can help estimate risks to the client from the disorder and help form predictions about prognosis. This section also presents "course modifiers," including protective factors that are known to ameliorate the effects of the mental health problem and/or "deleterious" factors that can exacerbate the course of the disorder (p. 26).

For example, we learn under the risk and prognostic factors that early childhood emotional trauma, parental psychopathology, and family conflict are risks factors associated with Bipolar Disorder—and that being married is less common among individuals with Bipolar I Disorder than those without the disorder (APA, 2022). Risk and prognosis material is invaluable to clinical work.

Culture-Related Diagnostic Issues. This critical section provides us with information intended to help buffer us against faulty clinical thinking due to culture-related dynamics and enhance our accuracy. This material comprises information on variations in symptoms, precipitants and causes, and differential prevalences across demographic groups. Material here also addresses cultural norms that can affect how pathology is perceived, and risks for misdiagnosis with marginalized groups, and other information aimed at enhanced culturally informed diagnosis. Remember that the Prevalence section may also provide helpful data in this regard. Among its examples of culture-related diagnostic content, the *DSM-5-TR* tells us that when considering the diagnosis of Brief Psychotic Disorder, one culture-related issue is that some

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religious ceremonies among certain cultures involve hearing voices, and these experiences should not be considered when making the diagnosis. You have already read about a case with similar considerations in this chapter's Clinical Spotlight 2.1. Similarly, the *DSM-5-TR* cautions us that cultural and socioeconomic differences between counselor and client must be considered when making the diagnosis of Schizophrenia to avoid misdiagnosis. This section is invaluable in order to address the impact of culture, racism, and marginalization in your own practice (APA, 2022).

Sex- and Gender-Related Diagnostic Issues. This material joins the culture-related diagnostic issues as another critical section providing material to help buffer us again faulty clinical thinking, here based on sex and gender. As you might guess, included in this category are "predominance of symptoms or the diagnosis by sex or gender, and any other sex- and gender-related diagnostic implications … such as differences in clinical course by sex or gender" (APA, 2022, p. 27). Interestingly, for example, the *DSM-5-TR* suggested there may not be much difference according to sex or gender in the prevalence or severity of Prolonged Grief Disorder. Remember once again that the Prevalence section may also provide helpful data in this regard. Earlier you read about a case with sex and gender considerations in this textbook's Clinical Spotlight 1.1. As with culture, this section is invaluable in order to address the effects of sex and gender dynamics and experiences in your counseling work (APA, 2022).

Functional Consequences. Along with risk and prognosis, the *DSM-5-TR* also may provide additional information about the likely functional consequences of a disorder in the individual's life. Usually these are consequences of the disorder that are likely to negatively affect an individual's daily functioning, such as successfully engaging in education, work, and independent living tasks. For example, the *DSM-5-TR* 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 essential 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 PTSD, we are encouraged in the text to alternatively consider Acute Stress Disorder, Major Depressive Disorder, Dissociative Disorder, Adjustment Disorder, and others (APA, 2022) because some of the symptoms and vulnerabilities of these disorders overlap.

Comorbidity. The Comorbidity subsection joins differential diagnosis as an essential diagnostic component. Comorbidity refers to the potential for co-occurrence of a mental disorder with

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one or more additional mental disorders or with one or more general medical conditions—that is, this section describes "conditions that are likely to co-occur with the diagnosis" (APA, 2022, p. 27). Competent clinicians must be aware of the potential for comorbidity when it is suggested. For instance, the *DSM-5-TR* reminds us that Major Depressive Disorder frequently co-occurs with substance-related disorders, panic disorder, some eating disorders, and others (APA, 2022). Similarly, the *DSM-5-TR* 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. Understanding comorbid tendencies will expand your vision of client needs and improve your ability to assist.

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 with meaningful information that will later contribute to the formulation of a case conceptualization and treatment plan.

FIGURE 2.4 ■ *DSM-5-TR* 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
Prevalence
Development and Course
Risk and Prognostic Factors
Culture-Related Diagnostic Issues
Sex- and Gender-Related Diagnostic Issues' Association with Suicidal Thoughts or Behavior
Functional Consequences
Differential Diagnosis
Comorbidity

INTERSECTIONS 2.1

ATTENTION TO CULTURE AND SOCIAL ISSUES, RACISM, AND DISCRIMINATION IN *DSM-5-TR*

As we have detailed in this chapter, the purpose of a mental health diagnosis is to describe our clients' presentations as accurately as possible. An accurate diagnosis provides a basis for forming a conceptual view of the client's needs, and in turn, allows us to effectively plan for change. However, the risk of diagnostic error in the outpatient or outclient medical world is a prevalent one that carries with it safety threats and other risks regarding the course of a disorder and of treatment (Perry et al., 2021). More specifically, these challenges often

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contribute to heightened health disparities among clientele from communities of color and other marginalized populations (Washington, 2006). Health disparities, according to the U.S. Center for Disease Control and Prevention (CDC), are defined as "preventable differences in the burden of disease, injury … or opportunities to achieve optimal health [which] are experienced by socially disadvantaged populations" (Kettlewell, 2021, p. 11). Generally, health disparities are among the most pressing entrenched social disadvantages that members of marginalized groups contend with. Our field is no exception. Speaking more narrowly about the mental health domain, we must be cognizant that clinical counseling work is "deeply affected by social and cultural constructions of race and ethnicity" (APA, 2022, p. 17). Fortunately, today's counseling professionals can find within the *DSM-5-TR* a variety of clinical and social advances intended to promote good diagnosis across intersections of client marginalization. These occur in all three of *DSM-5-TR's* sections.

As you begin your *DSM-5-TR* reading, you will find critical contextual discussions of cultural and structural issues that address the ways in which mental health disorders "are defined and recognized by clinicians and others in the context of local sociocultural and community norms and values" (APA, 2022, p. 16) within *Section I. DSM-5-TR Basics*. These contextual discussions emphasize the degree to which "[c]ultural contexts shape the experience and expression of the symptoms, signs, behaviors, and thresholds of severity that constitute criteria for diagnosis" (APA, 2022, p. 16). They also caution mental health practitioners about the profound impact of social and cultural constructions of race and ethnicity on clinical work—and outline the steps taken during the development and writing of the the *DSM-5-TR* to "address the impact of culture, racism, and discrimination on … diagnosis" (APA, 2022, p. 18). Altogether in the *DSM-5-TR's* Section I, you can find analyses of "Impact of Cultural Norms and Practices," "Cutlural Concepts of Distress," "Impact of Racism and Discrimination on [Mental Health] Diagnosis," and "Attention to Culture, Racism, and Discrimination" in the *DSM-5-TR*. Additionally, you will find a parallel section on sex and gender differences "as they relate to the causes and expression of [medical and mental health] conditions" (APA, 2022, p. 19).

As you continue on to the main component of the *DSM-5-TR*, in Section II: "Diagnostic Criteria and Codes," you will note that for every separate syndrome, the text provides known information, cautions, and/or guidance pertaining to diagnostic decision-making in the context of Prevalence (including population-specific data or sex ratio differences when available), Culture-Related Diagnostic Issues, and Sex- and Gender-Related Diagnostic Issues. Choosing just one example, under Schizophrenia, there are instructions for taking into account that the "form and content of schizophrenic symptoms can vary cross-culturally" (APA, 2022, p. 118). You are also cautioned that "[m]isdiagnosis of schizophrenia … is more likely to occur in members of underserved ethnic and racialized groups (in the United States, especially African Americans)" and are informed that "this may be attributable to clinical bias, racism, or discrimination leading to limited quality of information and potential misinterpretation of symptoms" (p. 119). Naturally, a relative drawback of such information is that it is limited to what is known at the moment from existing evidence, and therefore is dependent on each new clinical or social advance as the *DSM* system continues to evolve.

To wrap up, when you reach the supplemental Section III: "Emerging Measures and Models" at the back of the *DSM-5-TR*, you will see an additional chapter on on "integrating culture and social context in clinical diagnosis" (APA, 2022, p. 859). In this chapter, clinicians can find guidance about cultural formulations using systemic assessment of the client's cultural identity, cultural concepts of distress, and the cultural features of vulnerability and resilience that contribute to psychosocial stressors. There also is some guidance about negotiating the cultural features of the relationship between clients and clinicians, treatment team, and institution. For instance, the syndrome, *Attaque de nervios*, or "attack of

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nerves" found in Latinx cultural contexts and defined by "intense emotional upset, including anxiety, anger, or grief" and related symptoms, is covered in this auxiliary chapter on culture and diagnosis (our textbook's chapter 5 case of *Encanto's* Bruno, who arrives from a Latinx cultural context, conceptualizes Bruno's anxiety symptoms as *attaque de nervios*). While not a part of the formal diagnostic criteria comprising the *DSM-5-TR* classification system itself, this chapter covers ideas you may want to use as you engage with clients about "the impact of culture on key aspects of the individual's clinical presentation and care" (p. 862). You might find this chapter instructive as you develop your diagnostic and other clinical thinking skills.

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 Parkison's disease causing a Neurocognitive Disorder (illustrated in our text by the case of Mama Coco 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

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When they are needed, *ICD-10-CM* 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. Recall once again our textbook's Clinical Spotlight 1.1. In fact, you can find specific instructions for recording adverse effects of medication—for example, severe hypotension or cardiac arrhythmias—right inside the *DSM-5-TR*.

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 reread the intake summaries, diagnostic impressions, and diagnostic discussions for Naruto (Case 5.4), Maria (5.5), and Eleanor Rigby (Case 5.3), 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 Maria's pregnancy? 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

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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-TR* section titled "Other Conditions That May Be a Focus of Clinical Attention" found on *DSM-5-TR* pages 821-836. In this section, the *DSM-5-TR* identifies several categories of common social problems and environmental stressors. Included are:

- Suicidal Behavior and Nonsuicidal Self-Injury (including both suicidal and nonsuicidal self-injury)
- Abuse and Neglect (i.e., physical, sexual, or psychological abuse or maltreatment or neglect of a child, partner, or other adult)
- Relational Problems (e.g., problems related to the family environment, such as upbringing away from parents, or disruption of family by separation or divorce, and parent-child and sibling relational problems)
- Educational Problems (such illiteracy, underachievement in school, and problems related to inadequate teaching)
- Occupational Problems (such as unemployment, threat of job-loss, and problem related to current military deployment)
- Housing Problems (e.g., sheltered or unsheltered homelessness; discord with neighbor, lodger, or landlord)
- Economic Problems (e.g., food insecurity, extreme poverty)
- Problems Related to the Social Environment (such as problems related to living alone, social exclusion or rejection, and target of (perceived) adverse discrimination or persecution)
- Problems Related Interaction with the Legal System (problems with criminal proceedings, incarceration, release from prison, etc.)
- Problems Related to Other Psychosocial, Personal, and Environmental Circumstances (problems related to unwanted pregnancy, victim of crime, discord with social services provider, etc.)

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- Problems Related to Access to Medical and Other Health Care (unavailability or inaccessibility of facilities or agencies)
- Circumstances of Personal History (psychological trauma or military deployment)
- Other Health Service Encounters for Counseling and Medical Advice (genetic, sex, dietary, or other counseling)

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-TR* entry and accompanying code(s), all of which are easily found right in the *DSM-5-TR* text in the Other Conditions that May Be a Focus of Clinical Attention section. The following is an example:

- Other factors: 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 and life situation, and to our clinical thinking about 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-5-TR* section found on pages 821-836, and then turn to our twenty case

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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 reread the intake summaries and diagnostic impressions for as many cases as you can—and then answer the following questions:

What are some of the most common or most important psychosocial problems found among our twenty client illustrations? What are some of the most common or most important environmental problems found among our twenty clients? Are they problems with the clients' primary support group? Exposure to war, violence, or disasters? Educational or occupational problems? Acculturation 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 some type of competent assessment of the client's adjustment and resiliencies, the person's functioning in important life roles such as academic or occupational or parenting, and the levels of distress, vulnerabilities, symptom severity, and risk being experienced (APA, 2022). This information should appear somewhere in the clinical narrative to support and supplement the specific diagnoses you have selected. Today's professionals might utilize a variety of methods to indicate these assessments. First, using the *DSM-5-TR* 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 symptomatology, distress and impairment, and vulnerability and risk. Third, the *DSM-5-TR* text suggests several additional methods of assessment, including "cross-cutting symptom measures" (APA, 2022, p. 843), "clinician-rated dimensions of psychosis symptom severity" (p. 851), and the "World Health Organization Disability Assessment Schedule 2.0" (p. 854). Students, counseling and psychotherapy professionals in training, and counseling residents should be sure they acquire competencies pertaining to testing and measurement during their professional development (Seligman, 2004).

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SKILL AND LEARNING EXERCISE 2.10

BECOMING FAMILIAR WITH METHODS OF ASSESSMENT OF FUNCTIONING

Methods of assessment are included for all twenty 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. Students in programs leading to the counseling professions will cover these in detail in other courses and settings.)

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 twenty 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 applies their clinical thinking skills in order to derive a comprehensive diagnosis. Certainly, the first step in the learning process is to become familiar with the basics: what the *DSM-5-TR* 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-TR*'s limited scope and the *DSM-5-TR*'s interchapter organization should assist us.

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Ruling Out. Most of the diagnoses found in the *DSM-5-TR* 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, 2022). 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, 2022; 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 Stressor-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-TR* 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 their presenting problems with the avoidance and reexperiencing 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-TR* pages 313-315 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.

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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 non-diagnosable other conditions at all, are to be recorded, we indicate "no diagnosis," as in the following example:

Z03.89 No diagnosis or condition

Rounding Out the Diagnosis

The general medical conditions—other health problems—we record and the psychosocial and environmental problems—that is, other factors that may be a focus on clinical attention—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). For instance, it makes sense to indicate a pregnancy as a general medical condition when we use the diagnosis of Major Depressive Disorder with peripartum onset. 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). Here, for instance, it makes sense to indicate "acculturation difficulty" as a focus of clinical attention when we use the diagnosis of Adjustment Disorder to describe a client's "clinically significant" "development of emotional or behavioral symptoms in response to [this particular] identifiable stressor" (APA, 2022, p. 319). 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.

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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.

SCREENSHOT 2.1

DIAGNOSIS AT A DISTANCE: GROWING EVIDENCE AND A WORLD OF EXPERIENCE

In our previous chapter's Screenshot 1.1, we described the astonishing surge in telemedicine seen in the United States during and since the onset of the COVID-19 pandemic in 2020. We said that telemental health has accounted for nearly 40 percent of all outpatient telehealth appointments over the last few years—meaning, as we reported in the earlier Screenshot, that one in three outclient mental health visits are being delivered today by telehealth (Koma et al., 2021). Here in chapter 2, it is worth asking whether mental health diagnosis fits among these services. The U.S. Federal Communications Commission (FCC) already has embraced diagnostic procedures at a distance, defining telemedicine as "using telecommunications technologies to support the delivery of all kinds of medical, diagnostic and treatment-related services ... this includes diagnostic tests, monitoring a patient's [or client's] progress after treatment or therapy and facilitating access to specialists that are not located in the same place as the patient [or client]" (FCC, 2023, p. 1). At the same time, the Institute for Healthcare Improvement (IHI) cautions, "Telemedicine presents new challenges for diagnosis. Providers must learn how to address and overcome these risks when possible and determine when a virtual visit [is or is not] appropriate because the risk of diagnostic error [might be] too high" (Perry et al., 2021, p. 1). Fortunately, at this moment there is a growing body of research and an existing world of experience to support our diagnosis work at a distance.

The discussion about telediagnosis is a complex one. The IHI views diagnostic errors as one of the most prevalent safety issues in outpatient care and believes the risk can be further exacerbated by virtual office visits. Their concerns are that clinicians might have more forms of observation available to them in physical offices than through virtual mechanisms and so closer face-to-face involvement might reveal a more complete diagnostic picture (Perry et al. 2021). Still, the IHI recognizes that despite the potential risks, telediagnosis also has its significant advantages since "video-enabled office visits offer the opportunity to see the patient in context, and therefore providers may observe their living situation and see how they interact with their environment" (Perry et al. 2021, p. 1). In fact, the Society to Improve Diagnosis in Medecine (SIDM) found some of the same positives in their own investigations, reporting on "the value in being able to see into someone's home to better understand their

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familial and social context" (Graber & Schrandt, 2021, p. 4). Correspondingly, looking at the available evidence, a recent large-scale, wide-reaching study of diagnostic concordance between standard in-office and telemedicine visits found that in psychiatry, *ICD-10-CM* diagnostic agreement reached 96 percent (Demaerschalk et al., 2020). This finding is consistent with longer-standing telemedicine experiences in European Union countries where the use of telehealth including telediagnosis predates the COVID-19 pandemic by several years (such as in France, for example, where healthcare providers rely heavily on telehealth with its geriatric populations) (Piau et al., 2018; Zulfigar et al., 2018).

As follows, as you advance your own clinical thinking skills, some of the most important advice for mastering telediagnosis is to be sure to get adequate training in televisit best practices and in making diagnoses virtually, including how to conduct more limited assessments and how to look for signs and symptoms related to mental health via teletechnologies (Perry et al., 2021). Further, current best practices suggest that your training in this area should include learning how to engage and invite clients to demonstrate health- and mental health-related behaviors in the context of their natural environment, especially as you learn to look from a distance at clues about their life adaptation, their coping, and their problem-solving (Perry et al., 2021).

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-TR* diagnostic classification system. We said the *DSM-5-TR* 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-5-TR* 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-TR* 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

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client shows signs and symptoms of conditions contained in the *DSM-5-TR*, 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 life. These were summarized in Figure 2.2.

We explained how to use the *DSM-5-TR*'s interchapter and intrachapter organization to evaluate for the twenty main 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. We summarized these 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-TR.* 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. Among the chapter's boxes, Clinical Spotlights 2.1 and 2.2 relied on a career counseling client with psychotic symptoms and on a college counseling client with suicidality to showcase the importance of diagnostic decision-making in professional counseling settings. Intersections 2.1 then responded to counselor reservations about the *DSM-5-TR's* potential for bias, potential for stigmatization or labeling, and potential for underresponsiveness to social change by explaining how the system attends to culture and social issues, racism, and discrimination. And Screenshot 2.1 explored diagnosis at a distance through telemedicine methodologies.

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