

# Back to Basics: Using the *DSM-5* to Benefit Clients



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It is a pleasure to introduce this special *DSM-5* edition of *The Professional Counselor*, which provides a solid primer regarding changes in the *DSM-5* diagnosis process and how these changes will likely impact mental health professionals. Changes within the *DSM-5* have prompted counselors to revisit the basics of diagnosis and consider the cessation of certain conventions (e.g., the multiaxial system) and what these changes mean to counselors as they perform their vital work for the benefit of clients. The unprecedented inclusion of various mental health professionals in the development of the *DSM-5* is an inherent recognition of how this tool is being used across a wide range of professional disciplines that focus on psychopathology. I hope these articles not only inform, but encourage further research into the practical use of the *DSM-5*, “stimulate new clinical perspectives” in mental illness (American Psychiatric Association [APA], 2013, p. 10), and inspire continued professional dialogue around *DSM* nosology and the diagnostic processes.

**Keywords:** *DSM-5*, diagnosis, psychopathology, mental illness, multiaxial system

The fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders (DSM-5)* is an update of a major diagnostic tool (APA, 2013). The manual was originally designed to help mental health professionals within a wide variety of disciplines assess and conceptualize cases in which people were suffering from mental distress. This conceptualization is important in that it facilitates an understanding in a common language toward the development of treatment planning to address complex and entrenched symptomology. The *DSM* has undergone numerous iterations and represents the current knowledge of mental health professionals about mental illness (APA, 2013). One of the primary aims of the *DSM-5* workgroups was to align the manual with the current version of the *International Classification of Diseases (ICD-9)*. In addition, political, social, legal and cultural dynamics influenced the development of the *DSM-5*—and not without controversy (Greenberg, 2013; Locke, 2011; Linde, 2010; Pomeroy & Anderson, 2013). As with any tool, concerns have emerged about the potential of misuse. It is the professional responsibility of skilled and ethical mental health counselors and other professionals to prevent misapplication of the manual (American Counseling Association [ACA], 2014, E.1.b, E.5.a–d). Walsh (2007) succinctly noted that “the primary goal of the *DSM* is to enhance the care of individuals with psychiatric disorders” (p. S3).

The introduction of the *DSM-IV-TR* states that the *DSM* has been used by numerous mental health practitioners (APA, 2000), with no mention of their investment as legitimate stakeholders in the process of *DSM* development. Well before the final revision of the *DSM-5*, various mental health professionals, organizations and other relevant collaborators helped formulate the manual in unprecedented capacities. In the introduction to the *DSM-5* (APA, 2013) the authors intentionally state that numerous stakeholders were involved in *DSM-5* development including counselors and “patients, families, lawyers, consumer organizations, and advocacy groups” (p. 6). Of particular note was the inclusion of national organizations such as the ACA in the form of a

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*DSM-5* task force, which submitted position statements and recommendations to the APA. Various mental health professionals participated directly in the formulation of the *DSM-5*, primarily in field trials which “supplied valuable information about how proposed revisions performed in everyday clinical settings” (p. 8). Much of the data supports the use of more than 60 cross-cutting and severity symptom measures (see <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>).

### Clinical Utility

First (2010) reported that utilizing broad and diverse populations of mental health professionals provides rigor for clinical utility. Achieving clinical utility within the *DSM* diagnostic processes meets the following four objectives:

1. to help clinicians *communicate* clinical information to other practitioners, to patients and their families, and to health care systems administrators;
2. to help clinicians *implement effective interventions* in order to improve clinical outcomes;
3. to help clinicians *predict the future* in terms of clinical management needs and likely outcomes; and
4. to help clinicians *differentiate disorder from non-disorder* for the purpose of determining who might benefit from disorder-based treatments. (First, 2010, p. 466)

Any changes to the *DSM* were framed within the context of how they might be utilized by all mental health professionals, including revisions to definitions of diagnoses and symptoms, proposed diagnostic categories, dimensional assessment (including *cross-cutting*), and a renewed emphasis on severity specifiers. Ultimately, the consideration was whether the revised manual would be accepted and utilized by the practitioners it proposed to serve (APA, 2013; First, 2010). First (2010) noted that no mandate exists requiring the use of the *DSM* by any professional, and that other tools used to arrive at an *ICD* diagnosis exist or are in development (e.g., the NIMH Research Domain Criteria initiative; APA, 2013; Nussbaum, 2013). The *DSM-5* workgroups were challenged to revise the manual in order to make it user-friendly and maintain its relevance among mental health professionals. Even though the manual is an imperfect resource, the goal was to enhance clinical utility.

### Determining a Differential Diagnosis

In his primer on diagnostic assessment focused on the *DSM-5*, Nussbaum (2013) offers six considerations in determining a differential diagnosis that serve as an important basis for practice. These considerations or steps include the following:

- to what extent signs and symptoms may be intentionally produced;
- to what extent signs and symptoms are related to substances;
- to what extent signs and symptoms are related to another medical condition;
- to what extent signs and symptoms are related to a developmental conflict or stage;
- to what extent signs and symptoms are related to a mental disorder; and
- whether no mental disorder is present.

Each of these process steps serves as important reminders for getting back to the basics of rendering diagnoses that help inform treatment. When working with clients, these steps function as points of reference to rule out potential factors influencing misdiagnosis. Additionally, client cultural factors are essential at capturing comprehensive context for assessment and diagnosis.

**Consider to what extent signs and symptoms may be intentionally produced.** Signs and symptoms may be purposely feigned on the part of a client for secondary gain (e.g., financial benefits, drug seeking, disability status, attention from others, reinforcement of an identity of pathology, avoiding incarceration). Counselors

must recognize the context in which signs and symptoms occur and pay attention when something does not “fit” with how a client presents for treatment. Assessing prior mental health treatment (including outcomes), cultural factors and potential motives to fake an illness can assist counselors in making an accurate differential diagnosis.

**Consider to what extent signs and symptoms are related to substances.** A wise and influential professor and mentor during my graduate training said, “Always assess for substance use!” Clients can present with a variety of conditions that are induced by prescription or over-the-counter drugs, illicit substance, or herbal supplements (Nussbaum, 2013). An important emphasis within the *DSM-5* is substance-use and substance-induced disorders, which are included in many relevant diagnostic criteria (APA, 2013). Counselors are well-advised to make this determination in the initial assessment and continue to assess throughout the course of treatment.

**Consider to what extent signs and symptoms are related to another medical condition.** Clients present with signs and symptoms that may be caused by or coincident with another medical condition in a variety of ways. Nussbaum (2013) defined possible manifestations including (a) medical conditions that directly or indirectly alter signs and symptoms, (b) treatments for medical conditions that alter signs or symptoms, (c) mental disorders and/or treatments that may cause or exacerbate medical conditions, or (d) both a mental disorder and a medical condition that are not causally related. Counselors should gather medical information from the client and appropriately follow up with medical personnel as needed to ensure proper and accurate diagnosis, which will lead to more targeted and effective treatment.

**Consider to what extent signs and symptoms are related to a developmental conflict or stage.** A primary strength of counseling professional identity is the focus on human development as a key factor in client distress and resiliency. The counseling practice of “meeting clients where they are” includes where they are developmentally. Counselors must recognize where incongruence exists between what clients present and the expected behaviors or characteristics of their particular developmental stage. Nussbaum (2013) stresses the importance of gathering a comprehensive psychosocial history to determine expected developmental milestones. Being on the lookout for developmental delays, regressive behaviors of an earlier developmental period, primal defense mechanisms, or signs of “a developmental conflict in a particular relationship” (p. 201) will help ensure that all essential contextual factors are addressed when making a diagnosis.

**Consider to what extent signs and symptoms are related to a mental disorder.** The definition of mental disorder has not changed significantly from previous versions of the *DSM*: a mental disorder is “a syndrome characterized by clinically significant disturbance in...cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes...[and] usually associated with significant distress or disability in social, occupational, or other important activities” (APA, 2013, p. 20). Identifying mental disorders, or the process of diagnosis, involves more than clear-cut observations and often includes the consideration of complex factors involving comorbidity, symptom clusters “that may be part of a more complex and unified syndrome that has been artificially split in the diagnostic system” (Nussbaum, 2013, p. 202), overlap between diagnostic criteria, genetic predisposition, and the mutual influence of two or more conditions. Counselors must be careful to consider the presence of these factors, consult when necessary, and take into account differential diagnosis to determine the most appropriate diagnosis given the verbal and observable data available.

**Consider whether no mental disorder is present.** Sometimes a client may present with symptoms that do not meet the full diagnostic criteria for a mental disorder, despite significant distress in social, occupational or other areas of functioning. In these cases, utilizing the *not otherwise specified* or *unspecified* diagnoses may be

warranted in order to provide opportunities for deeper inquiry. For example, the symptoms of a disorder may be a secondary reaction to an identifiable social stressor that may justify a diagnosis of an adjustment disorder. The possibility exists that there may not be a diagnosis present (Nussbaum, 2013), and in these cases, counselors and other mental health professionals are challenged to make that decision in the face of pressures to diagnose.

## Cultural Implications

It is imperative that counselors take their clients' social and cultural influences into account when assessing and diagnosing. Culture impacts all aspects of diagnosis and treatment, including how and when treatment is sought; power differentials between clients and mental health professionals; the age, gender, ethnicity, race, religion, sexual orientation, and socioeconomic status of both clients and mental health professionals; how illness is defined by both; and how problems are conceptualized and addressed within the context of culture (Lewis-Fernández et al., 2014; Tomlinson-Clarke & Georges, 2014).

Two decades of experience using the Outline for Cultural Formulation (OCR), which was introduced in the *DSM-IV* (APA, 1994), evolved into the Cultural Formulation Interview (CFI) now contained in the *DSM-5*, comprised of 16 semi-structured questions designed to collect data in a more consistent and efficient manner. Like other dimensional, cross-cutting and severity measures developed specifically for the *DSM-5*, the CFI was field tested at 12 sites representing several countries to determine feasibility and usefulness (Lewis-Fernández et al., 2014). For the first time, culture in its varied manifestations has been intentionally incorporated into the *DSM* nosology through a specific assessment instrument. "The CFI follows a person-centered approach to cultural assessment...designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help" (APA, 2013, p. 751). Counselors are encouraged to utilize the CFI as a way to understand their clients more meaningfully and to aid in clinical utility.

## The *TPC* Special Issue: Counseling and the *DSM-5*

Because the *DSM-5* is a tool for mental health professionals to utilize in their conceptualization of client distress, understanding how to use the *DSM* effectively is at the heart of this special issue published by *The Professional Counselor (TPC)*. Readers will find a variety of articles that will assist mental health professionals by providing important context for most of the salient changes within the *DSM-5* (APA, 2013) from the perspective of professional counseling. Inherent in each of these contributions is the theme of getting back to the basics in not only understanding the *DSM-5* conceptually, but also providing ideas for putting concepts into practice.

An essential element in understanding and using the *DSM-5* effectively is exploring the foundational and historical roots of this complex nosology. Dailey, Gill, Karl, and Barrio Minton (2014); Gintner (2014); and Kress, Barrio Minton, Adamson, Paylo and Pope (2014) offer excellent overviews of salient changes within the *DSM-5* that impact clinical practice, including how the *DSM* has evolved over time. While there is necessary redundancy on key points (e.g., elimination of the multi-axial format, implementation of cross-cutting symptom measures, closer alignment with the *ICD* coding system), each article provides an important and unique perspective. Dailey et al. (2014) offer important perceptions on changes within the *DSM-5* including how changes evolved historically and the philosophical foundations behind those changes, especially those that clash with the philosophical underpinnings of counseling. The authors review the implications of such changes for professional counselors. Gintner (2014) provides an excellent context regarding the harmonization of the *DSM-5* with the *ICD*, the inclusion of cross-cutting symptom measures and dimensional assessment, and how the manual is organized. The article focuses on how counselors might respond to these changes. Kress et al. (2014)

offer an important perspective on the removal of the multi-axial convention used by mental health professionals for over three decades and the implications for counselors in the practice of assessment and diagnosis. These authors provide an important context for the decision to terminate the multi-axial system including advantages and disadvantages of *DSM-5* changes.

King (2014) describes the practical application of diagnostic criteria and the use of cross-cutting dimensional assessments. This perspective offers a backdrop on which to compare current practice and how it may alter with use of the *DSM-5*. This article focuses on clinical utility and ensuring that the *DSM-5* remains a guide to assessment, diagnosis and treatment. Schmit and Balkin (2014) give a comprehensive review of the cross-cutting, dimensional and severity measures from the perspective of psychometric instrumentation, including the practical application of validity and reliability. These authors underscore *DSM-5* assessments as *soft measures* and provide important cautions to counselors using these instruments in their work with clients, including the importance of developing multiple data points.

Understanding specific diagnostic categories is essential to good clinical practice. Welfare and Cook (2014); Kenny, Ward-Lichterman and Abdelmonem (2014); and Jones and Cureton (2014) provide solid descriptions of specific diagnostic criteria and emphasize areas essential to our understanding of developmental and demographic strata. Welfare and Cook (2014) tackle chronic and persistent mental illness manifested in diagnoses within the following categories: schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, and depressive disorders. Clinical examples help contextualize the process of assessing and diagnosing these disorders and provide a detailed example of effectively utilizing each step of the diagnostic process. Kenny et al. (2014) provide a cogent overview of the changes made to the “Feeding and Eating Disorders” chapter, including the addition of binge eating and avoidant/restrictive food intake disorders, severity criteria for anorexia nervosa based on body mass indexes, and how the diagnosis of eating disorder not otherwise specified (EDNOS) has changed as a result. Jones and Cureton (2014) offer important perspectives on significant changes to the “Trauma- and Stressor-Related Disorders” chapter and how these changes may impact clinical practice. The authors discuss how diagnostic criteria have been developed for both children and adults and how cross-cutting symptoms (e.g., panic and dissociation) manifest in a range of disorders. Another significant change to this category is the acknowledgement of sexual abuse as a traumatic event; this takes post-traumatic stress disorder (PTSD) out of the often associated realm of combat veterans and into more common and insidious manifestations of trauma.

Counselors should consider the aforementioned changes to the *DSM-5* in the context of their counselor identity. Maintaining professional identity and promoting a wellness- and strength-based perspective continues to be an important concern for the counseling profession and the training of counselors. Tomlinson-Clarke and Georges (2014) provide an overview of maintaining professional identity in the process of assessment and diagnosis within a system representing the medical model. A particular strength is the inclusion of how multicultural competency is crucial in using the *DSM-5* effectively, which is an essential basic foundation to sound practice. Implications for counselor preparation also are a focus. Finally, Frances (2014) provides a critical commentary of how the *DSM* has been used by pharmaceutical companies to leverage significant profits at the cost to consumers of mental health services and our economy. As the former chair of the *DSM-IV* task force, Frances reminds counselors and other mental health professionals of their essential place within treatment and cautions counselors to use the *DSM* in a balanced manner. His comments are consistent with advocacy inherent in our profession for treatments that promote client resilience, and address psychosocial and environmental factors that impact client functioning.



## Conclusions

This special *TPC* issue on counseling and the *DSM-5* provides a compilation of articles covering the history of the *DSM*, structural and categorical changes, the process of diagnosis, implications for practice, and cautions and criticisms. These articles validate the unique and important perspective counselors bring to their work, and challenge all mental health professionals to use the *DSM-5* accurately. The *DSM* continues to evolve, and its advocates have made significant strides in reaching out to a variety of professionals; one manifestation of this outreach is the development of the *DSM-5* website (see <http://www.psychiatry.org/practice/dsm/dsm5>). Counselors have the opportunity to use the *DSM-5*, provide feedback directly to the APA, and help shape and influence future editions of this diagnostic tool. This is an important way counselors can advocate for their clients as well as their profession, and shape how the *DSM* is used to help treat those suffering from mental and emotional distress.

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