

1 Making Sense of the DSM 5

The Diagnostic and Statistical Manual of Mental Disorders, commonly known as the DSM 5, is the dominant model for diagnosing mental health concerns in the United States. The fifth edition marks the most dramatic, and most highly contested, revision of the manual since its earliest conception in 1844, when the American Psychiatric Association (APA) first attempted to classify institutionalized persons. The APA published the first edition with this name in 1952 (American Psychological Association, 2013/1952). The DSM in all its iterations has been both widely embraced but also deeply criticized. This chapter will describe the purpose of the DSM 5, explore some of the key concerns about the book and the medical model it represents, and will offer guidance into how to navigate the DSM 5 and its current format.

The Purpose of the DSM

The purpose of the DSM is to describe and classify mental health disorders. A classification system is important in order to create a common language for communicating with other helping professionals about client concerns. Without a reliable and valid classification system, it is difficult to conduct research to understand how common a disorder is, which population may be most likely to experience a disorder, and most importantly, how a disorder might best be treated. If the classification system isn't trustworthy, then we can't know if different researchers are describing the same concerns, making it difficult to arrive at a place of confidence that recommendations born out of research can be expected to be helpful with the clients we see in clinical settings. The APA's stated aim in developing and continuing to revise the DSM is to best reflect current research about mental disorders, their symptoms and prevalence, and to clarify and refine diagnostic criteria. Consequently, the manual has been revised several times since its first printing to reflect current research and to respond to changing understandings around what constitutes disorder (American Psychological Association, 2013).

The Constructivist Nature of Mental Health and Mental Illness

When a person's body has difficulty producing insulin and responds to sugars in such a way as to threaten that person's life, this process is described as diabetes. We can apply more specific language to the term "diabetes" depending upon when signs of illness first began, in childhood or later in life. The word diabetes serves as a helpful shorthand to doctors in conveying to one another that a patient presents with a particular cluster of symptoms, physical and sometimes cognitive in nature, as well as to the physiological obstacles, such as a failure to produce sufficient amounts of needed insulin or to properly make use of insulin. This very brief communication through the diagnosis of diabetes also helps to lead doctors quickly to a set of potentially life-saving interventions.

The DSM also represents an attempt to create both a framework and a shorthand for communicating clients' experiences of emotional and cognitive difficulties. However, unlike the example of a person with diabetes, there are no dependable blood tests for commonly diagnosed mental health concerns such as depression, anxiety, or psychotic processes. Mental health concerns, such as depression, arise out of a variety of causes that aren't easily traced to biological markers. What's more, states of experiencing, such as deep and unrelenting feelings of sadness, are individual, subjective, and given to differences in cultural interpretation and expression, and are not as easily quantified as a blood sugar level. Consequently, the process of categorizing, describing, and quantifying mental health concerns is much more complicated than illnesses that arise from the physical body.

As a vastly diverse society, it is difficult to describe any single behavior or experience as "normal" for all groups and more difficult still to create a shorthand for a subjective experience that makes sense within the context of every culture, every age group, gender or sexual orientation, further complicating the already challenging task of cataloguing mental health concerns. While diabetes is a process that can be identified tangibly and acts and reacts in more or less predictable ways, depression and other mental health concerns can't be understood in the same way. For these reasons, what we have come to call a major depressive disorder (MDD), for example, is something more along the lines of a social construction than a disorder of the same quality of a medical disorder, such as diabetes.

A social construction, for these purposes, simply refers to the practice of developing a shared understanding of an idea or, in this case, an experience. Experiences of debilitating and lasting sadness are as varied as the people who experience them. However, for the sake of communication and in order to better facilitate our intervention, mental health professionals have agreed, for example, to describe a particular cluster of experiences of sadness as MDD and to discern that cluster from another subset of experiences that also includes sadness as persistent depressive disorder.

It is important to remember that our understanding of mental health disorders is evolving and the DSM is under constant review. Shifts in the mental health profession's understanding of any given disorder or continuum are prompted by innovations

in neuroscience, gains in the understanding of cultural influences and differences in both presentation and intervention that exist between groups. Shifting attitudes within Western culture have also influenced how mental disorders are conceptualized and fundamentally shape what is understood to fall within normal experiencing or behavior and what is understood to be problematic enough to be described as disordered. A key example of shifting cultural beliefs that have shaped diagnosis is illustrated in the changes in the way that the DSM has treated sexual orientation. With the publication of the DSM III homosexuality was dropped as a diagnosable disorder except in those cases when same-sex attractions were the source of distress, which was described as ego dystonic homosexuality. However, in the DSM III-R, this diagnosis was dropped and the distress a person felt arising from same-sex attractions was diagnosed as a sexual disorder not otherwise specified. This disorder was maintained in each edition that followed until the DSM 5, where mention of same-sex attractions and distress are no longer included. It stands to reason, then, that as we make use of the DSM 5, we keep in mind that this manual is a reflection of the APA's best understanding of the current research literature. The descriptions included within the DSM 5 are not uncontested.

Alternative Frameworks for Understanding Mental Illness

Alternative approaches to the DSM 5 are currently in use but don't enjoy the same kind of attention and popular application. For example, a system of understanding mental health concerns can be found in the Psychodynamic Diagnostic Manual (PDM-2), a manual that is embedded in psychodynamic models of understanding the manifestations of mental disorders. The PDM-2 features a much greater focus on personality structure than does the DSM 5. The PDM-2 offers attention to dimensions of functioning as well as insights into the use of defense mechanisms. The PDM-2 also offers typical belief structures about self and others within each of the outlined personality structures (Lingiardi & McWilliams, 2017).

While the DSM is the most widely used classification system in the United States, the International Classification of Diagnoses (ICD) enjoys the most use worldwide and is currently in its 11th edition. The ICD is published in collaboration with the World Health Organization and is used in collecting data and in research on physical and mental disorders across the globe. The ICD coding system works to capture not only the nature of physical illnesses and mental health disorders but also their etiology (Goodheart, 2014), something the DSM classification system has attempted to avoid.

Many mental health clinicians, however, see mental health concerns as directly tied to the workings of the brain, and embrace a more biologically based system (psycho-physiological) of understanding mental disorders than the DSM describes. For these clinicians, the Research Domain Criteria (RDoC) offers a science-based classification. Sponsored by the National Institutes of Health, the RDoC attempts to map diagnostic

domains and syndromes around neurological dysfunction. This system is still in its infancy (Cuthbert & Insel, 2012; Insel et al., 2010).

Another relatively new initiative to create an alternative diagnostic framework comes out of the Global Summit on Diagnostic Alternatives. This group aims to create a system that meets the following criteria: (1) to give equal attention to sociocultural contributions to mental health concerns as is given to biological causes; (2) to give attention to categories of problems, rather than categorizing people; (3) to give equal consideration to the science related to sociocultural etiologies as is given to biological etiologies; (4) to emphasize collaboration between the client and the clinician in the diagnostic process and (5) developing a system that can be used across theoretical domains (Raskin, 2014).

Non-Western approaches have worked to organize mental health concerns as well. For instance, contemplative psychotherapy, an approach based in Tibetan Buddhist psychology, organizes disorders by their resemblance to samsaric preoccupations known as the six realms and includes the realm of the gods, the realm of the jealous gods, the human realm, the animal realm, the realm of the hungry ghosts, and the hell realm. Within this conceptualization of mental health concerns, addictions, for example, are described as being rooted within the hungry ghost realm, a state of being in which desires are many but the capacity for feeling satisfied is impaired (Trungpa, 2010; Wegela, 2014). Similar to the PDM-2, this system focuses on ways of seeing and engaging the world and the ways in which each perspective causes suffering.

Any framework for understanding mental illness will be constructed within a cultural frame and worldview and will be built on a theory describing the etiology of disorder. Sometimes the grounding theory of the model is readily apparent and sometimes it is much more subtle, as with the DSM 5. A quick internet search of these alternative approaches or of the DSM 5 itself reveals that clinicians tend to hold strong opinions about the utility and validity of these systems. Perhaps as you read through this discussion, you found yourself drawn to or curious about one system or noticed an instant distaste for another?

Criticisms of the DSM 5

The draft of the DSM 5 was much anticipated. Many clinicians had expressed concerns about the gaps between the disorders represented in the DSM IV-TR and available research. However, soon after the draft was posted for commentary from the mental health community, criticisms and concerns were raised. The Society of Humanistic Psychology, a division of the American Psychological Association, in partnership with the British Psychological Society penned an open letter to the DSM 5 task force and was joined by 11 other APA divisions endorsing the statement. These divisions included but were not exclusive to the following: The Division of Developmental Psychology; The Division of Psychotherapy; The Society for the Psychology of Women; The Society for the Psychological Study of Ethnic Minority Issues and The Society for

BOX 1.01 CONSIDER THIS: REFLECTING ON YOUR BELIEFS AND PREFERENCES

As you consider your responses to each of the alternative approaches to the DSM 5, what might your response reveal about your own beliefs and worldviews? What do your preferences suggest about the ways you may come to understand your

clients and their difficulties? How might your preferences suggest something to you about how you may go about selecting interventions with and for your clients?

the Psychological Study of Lesbian, Gay, Bisexual and Transgender (LGBT) Issues. These divisions were soon joined by professional organizations within the counseling field as well as notable international organizations, including but not exclusive to The Association of Black Psychologists, Counselors for Social Justice; The Association of LGBT Issues in Counseling; National Latina/o Psychological Association; the UK Council for Psychotherapy and so on (Coalition for DSM-5 Reform, 2012). In addition to key professional organizations, the DSM 5 draft received strong criticism from notable leaders in the field, including Dr. Allen Frances, Task Force Chair of the DSM IV-TR, and Dr. Robert Spitzer, Chair of the DSM III.

Contained within the concerns outlined in the open letter coauthored by the American Psychological Association and the British Psychological Society and mirrored in an open letter from the American Counseling Association (2014b), are concerns that remain after the DSM 5's publication, though other concerns not listed here were addressed. These concerns seem to fall into three overarching categories: (1) a lowering of diagnostic thresholds that may have the effect of pathologizing normal human experiencing, such as bereavement, and unfairly targeting vulnerable populations; (2) the inclusion of new diagnoses with little empirical support and (3) a theoretical orientation embedded in biology and neuroscience that is not well supported with scientific evidence, ignores social and relational causes of mental health concerns, and may result in unnecessary and dangerous pharmacological treatment of mental health concerns (Society for Humanistic Society, 2011; Coalition for DSM-5 Reform, 2012).

Another criticism arose around the language in the draft defining mental disorder. Concern was raised that the wording in the draft made it possible to diagnose differences in political or religious views that contrasted enough from the mainstream to

place the client in conflict with society at large (Coalition for DSM-5 Reform, 2012). The language on page 20 of the DSM 5 now reads this way:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (i.e., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Here, the phrase "socially deviant behavior" refers to behavior or beliefs that depart from the mainstream, such as political or religious beliefs, or sexual practices. The stance taken in the DSM 5 is that while some religious or political views may stand in conflict with the broader social perspective, such as White supremacist views, these views by themselves do not constitute a mental disorder. However, these views may be symptomatic of disorder when the beliefs are born out of cognitive or emotional disturbances, such as paranoid processes.

Poor Inter-Rater Reliability

Decades old research demonstrates that diagnosticians have had difficulty arriving at the same diagnosis when given case scenarios to diagnose, often described as inter-rater reliability (Beck, 1962; Spitzer & Fleiss, 1974). Freedman et al. (2013) and his colleagues conducted a field study of the DSM 5, which resulted in disappointing inter-rater reliability rates even for commonly diagnosed disorders such as MDD ($\kappa=.28$) and generalized anxiety disorder ($\kappa=.20$). These studies suggest three key points: (1) mental health practitioners, and diagnosticians in particular, need a more reliable structure for arriving at an appropriate diagnosis; (2) a format is needed for conveying the reasoning behind a particular diagnosis or diagnoses and (3) this research supports concerns expressed about a lack of clarity within the wording of the DSM 5 itself. The justification process (Hammond, 2015), described in Chapter 3, is a procedure that provides the students new to diagnosis with an avenue for arriving at and supporting a particular diagnosis. Research is needed to explore whether using this structure increases inter-rater reliability, however. Low inter-rater reliability due to ambiguous language, differences in the ways clinicians interpret client complaints and symptoms, and those born out of structural bias within the DSM itself, however, will be harder for clinicians to work around. Careful use of key diagnostic principles may support more accurate diagnosis.

Validity Questions

A significant portion of the criticisms of the DSM 5 and its previous editions centers around the question of validity. Recall that when we are discussing the validity of an assessment measure or tool, we are describing how well a tool does what it claims to do. We can explore this question more deeply by looking at construct validity, which assesses whether or not a tool measures the underlying psychological construct that it aims to measure. When clinicians evaluate the question of the validity of the DSM 5, we are asking at least four questions:

1. “Does this tool measure what it claims to measure?”
2. “Does the manual reflect the data available in the research?”
3. “Does the DSM 5 reflect what I see in my practice with clients?”
4. “Does the DSM 5 provide useful predictive value in describing the course of my client’s disorder?”

Measuring what it claims to measure and reflecting current research. Unlike most other assessment tools, the DSM 5 attempts to describe a great number of psychological constructs: dimensions, disorders and indeed the symptoms outlined within each. Consequently, in order to answer the construct validity question, we are challenged to evaluate the manual dimension by dimension and disorder by disorder. Since its publication, a steady stream of research has been undertaken to determine the manual’s validity; for example, in the areas of autism spectrum disorder (Mandy et al., 2012), borderline personality disorder (Anderson & Sellbom, 2015), on the somatic symptom disorders (Häuser et al., 2015) and for the DSM’s personality assessment tool, the PID-5-BF, for use in older adults (Debast et al., 2017), to name a few. It is validity research that will continue to inform the future changes to the DSM.

Does the DSM 5 reflect what we see in the clinical setting? The American Psychological Association and the National Council on Measurement in Education offer another way to think about validity, “the extent to which inferences made from [the tool] are appropriate, meaningful, and useful,” (Salkind, 2019, p. 64). Considering whether or not inferences made from using the DSM 5 are appropriate, meaningful or useful to our work with clients may depend a bit on who is asked. While many agree that the DSM 5’s symptom checklist format is useful for research purposes, others question its usefulness in clinical work, and many go so far as to question whether the DSM 5 is, in fact, unhelpful (Pies, 2012). Perhaps more telling, Zimmerman and Galione (2010) conducted a study of psychiatrists and non-psychiatrists in mental health professions and found that a quarter of psychiatrists and two-thirds of non-psychiatrists surveyed used the DSM IV-TR less than half of the time when diagnosing MDD, citing the over-simplification of the disorder as it is represented in the manual. This suggests that professional diagnosticians have not always found the DSM to be useful.

Racism and other forms of bias. Concerns regarding bias in the diagnostic process can be discussed within two primary categories: problems that are built into the structure of the DSM itself and problems that arise within the person doing the diagnosing. The DSM is based upon a medical model of disorder that assumes that the illness arises from within the individual and consequently gives little attention to those stress reactions that arise out of the context in which the individual is living. Volumes have been written connecting racism, sexism, homophobia and socioeconomic stressors to mental health concerns. Take for instance experiences of microaggressions, subtle, brief and sometimes unintended forms of discrimination. Microaggressions have been tied to cultural mistrust and decreased well-being in Asian Americans (Kim et al., 2017). Similarly, daily microaggressions have been positively correlated with depression and suicidality in bisexual women (Salim et al., 2019); depressive symptoms and negative affect in African Americans (Nadal et al., 2014) and somatic symptoms, externalizing symptoms and aggressive behavior in homeless youth (Sisselman-Borgia et al., 2018). Many object to the notion that an individual who experiences sadness, anger, sleeplessness, hopelessness, loss of interest and restlessness as a result of daily experiences of racism or other forms of oppression would be pathologized rather than naming and addressing the source of the problem.

Another long-standing concern about the medical model of the DSM is that it assumes that the presentations of each disorder are universal and reflect the experiences of all cultural groups. Research studies on the presentation and treatment of mental disorders have long been criticized for poorly representing minority groups and assert that the bulk of published research more accurately describes White, middle class clients. Further, the manual and its conceptualization of what is normal and what is abnormal is essentially embedded in dominant cultural values and rarely on biomedical markers (Jun, 2010).

The authors of the DSM IV-TR and of the DSM 5 have worked to include culture-related diagnostic issues within the discussion sections of many of the disorders; however, these are frequently brief notations and require first that the diagnostician consult the discussion sections of the DSM and not just the criterion tables, and often require the clinician to explore further into cultural norms specific to their clients. For example, the culture-related diagnostic issues for separation anxiety disorder correctly notes that cultures vary widely in their expectations for relative interdependence or independence. The discussion does not offer examples, making it necessary for the clinician to do some research about a particular client's cultural expectations and to consider how closely a client falls within those expectations. Consequently, ethical use of the DSM 5 presupposes clinical multicultural competencies.

Added to this edition of the DSM is a chapter dedicated to the exploration of cultural context and mental health. The chapter, *Cultural Formulation*, provides a caution about the importance of considering cultural identity, cultural conceptualizations of distress, features of vulnerability and resilience and therapeutic relational dynamics and their intersection with culture. Provided within this chapter is the *Cultural*

Formulation Interview that offers a structure and guide for diagnosticians for use at intake. This edition also retains the *Glossary of Cultural Concepts of Distress* (American Psychological Association, 2013). However, Thornton (2017) argues that while the DSM does seem to strive to achieve both validity and cultural sensitivity, the glossary of cultural concepts remains a mere afterthought.

Today we are still grappling with the consequences of racist practices in medicine and psychology. A deep stream of distrust of the psychology profession is still present within marginalized populations. Racism and other forms of bias still threaten the diagnostic and treatment process and consequently the DSM 5 can also be used in ways that reinforce these abuses. It is the streams of personal bias that individual diagnosticians have the most immediate power over in their day-to-day work. Consequently, understanding how individual bias can manifest in our work and being attuned to these issues can help to reduce the impact of individual bias on our clients. Poland and Caplan (2004) offer several examples in which bias finds its way into the diagnostic process:

1. Clinicians often focus on some types of information and exclude others or privilege certain sources of information over others.
2. Clinicians frequently make judgments about whether or not a client's feelings or behavior are pathological without having spent adequate time with the client to make an informed assessment.
3. Clinicians may more readily judge women, people of color or the poor to be mentally ill than men, White people or the middle class or the wealthy.
4. Clinicians may be prone to taking at face value the statements made by male clients over those made by women, by White clients in contrast to clients of minority statuses, or of wealthy or middle-class clients over those that struggle with poverty.

Caplan and Cosgrove (2004) also offer a helpful reminder about sources of bias that arise out of unhelpful dynamics or emerge from the personal psychology of the clinician. Some of these processes that impact diagnosis include unchallenged stereotypes about others, or encountering a client who is reminiscent of someone who is disliked. Cognitive processes that can generate bias might include giving greater attention to information gathered early in the diagnostic process over information gathered later, known as anchoring bias. The workings of confirmation bias, in which a diagnostician forgets or minimizes information that conflicts with an original hunch, also figures into diagnostic bias. Availability bias, another source of skewed diagnosis, is a tendency for the mind to lend importance to information that is easier to remember and to disregard other pieces of relevant data. Finally, a "stereotyped memory" bias is a process in which the mind creates inaccurate memories that fit stereotypes of a group but not the actual person being evaluated (Caplan & Cosgrove, 2004).

Lack of clarity and poor wording choices. In addition to the problems listed above, Frances (2013) has mirrored concerns offered by divisions of the American Counseling Association and American Psychological Association related to the reconceptualization of the book as well as about a lack of clarity in the writing itself that he feels will lead to increased inaccuracies in diagnosis and lowered inter-rater reliability.

By way of example, Frances (2013) drew attention to a lack of clarity about how many of the “A” sub-criterion must be met in Autistic Spectrum Disorder, leaving it up to the clinician to decide if only one or all three of the sub-criteria should be met in order to diagnose. Frances also voiced concerns about phrasing within the DSM 5 that may dramatically lower the threshold for what is a diagnosable disorder, as with MDD and Mild Neurocognitive Disorder. In fact, since the publication of the DSM 5 in 2013, the APA has published two supplements that offer revisions that clarify ambiguities, including the criterion requirements for a diagnosis of autism. A discussion of the DSM 5 Supplements can be found at the end of this chapter and instructions for their use are described in Chapter 2, *Eight Steps to Diagnosis*.

Frances, 2013, also points to an example of poor judgment in language illustrated in the attempt to clarify the difference between a pedophilic disorder from a sexual preference for children that has never been acted upon and does not cause any functional or emotional distress. The DSM 5 describes the latter as a “pedophilic sexual orientation but not a pedophilic disorder.” The importance of separating disturbing thoughts and urges that result in functional, behavioral or emotional impairment (disorder) is a key diagnostic principle. However, the implications of using the wording “pedophilic sexual orientation” rather than “pedophilic sexual preference/inclination/compulsion” lends pedophilic thoughts the same kind of languaging as is used to describe LGBT sexual orientations. The scientific community is in agreement that homosexuality is not a disorder, though it had been included within the DSM until 1974 (Drescher, 2010). It seems both unwise and inappropriate to employ similar language to describe such a destructive sexual compulsion (pedophilia) with what is understood to be one end of the normal continuum of human sexuality (homosexuality).

Other Criticisms

A variety of additional concerns swirl around the latest edition of the DSM. Many organizations, including the American Counseling Association, have pointed to what seems to be a conflict of interest between those who serve as task force members while also maintaining financial or research relationships with pharmacology companies. Seventy percent of the task force members also have ties with pharmaceutical companies who stand to gain from lowered diagnostic thresholds of disorders (Moisse, 2012).

Finally, a criticism of the DSM as a whole is that when diagnosticians embrace this nosology as a diagnostic model, they place the DSM in a position of power within the clinical relationship and distance the clinician from the client:

BOX 1.02 CONSIDER THIS

Multicultural competence is essential to the ethical use of the DSM and the diagnostic process.

“Meanwhile, we have lost sight of one of the most important motivations of the anti-psychiatric movement, namely, to address the typically authoritarian relation between the expert and the patient. So, the final question is: Has the DSM diagnostic changed anything in the relationship between diagnosticians and patients? The answer is an unqualified no. From such a perspective, the expert remains an objective observer who inspects an object of study . . .” (Verhaeghe, 2019, p. 31).

Social Trends and Diagnostics

While societal attitudes about most physical health issues tend to hold less stigma than they did at one time in our history, societal attitudes about mental health concerns are still heavily burdened by social stigma and misunderstanding. Consequently, many mental health professionals are reluctant to use the DSM (Kress et al., 2010). Other clinicians are averse to using the DSM because it is seen as equating difficult emotional states or phenomena with physiological states of illness, an approach described as a medical model for mental health diagnoses. Many of the concerns about the DSM and its structure are embedded in philosophical questions that pertain to the practitioner’s theory related to the connection or disconnection between mind and body and particularly to the relative centrality of the physical brain or the complex phenomena of mind in the manifestation of suffering.

It is also important to note that our understanding of what it means to be mentally fit is both a social construction and is informed by the clinician’s individual theoretical perspective. By way of example, some, such as those who embrace cognitive therapy, would view anxiety as a consequence of faulty thinking that, with support, could be remedied. Other theoretical approaches, however, view anxiety as part and parcel of the human condition, such as psychodynamic, existential or contemplative frameworks, although each of these three would differ in their understanding of the source of this anxiety and would differ significantly in how to go about working with a client presenting with anxiety.

Minimizing Risk

The Table 1.01 Criticisms of the DSM 5 and Recommended Actions outlines the key criticisms of the DSM 5 and offers recommended actions or safeguards that may help support clinicians in avoiding the pitfalls embedded within the DSM 5.

Importance of Mastering the DSM 5

The reader might reasonably ask, “When faced with these criticisms what is the utility of learning the DSM in my training program or in using it in my practice?” The DSM 5 is currently the language of the field. If you hope to navigate the research and literature related to intervention, you must be able to understand what is being described. As clinicians, we must be able to communicate client concerns in a way that other mental health professionals can understand. And if we hope to contribute to the process of shaping and clarifying diagnostic processes, then we must be able to work effectively within the DSM system. A comprehensive understanding of concerns related to this model of diagnostics strengthens our ability to use it ethically (American Counseling Association, 2014b; American Psychological Association, 2013). Further, a decision to use an alternative diagnostic system is arguably made more sound when clinicians understand the DSM as well as their preferred diagnostic model. And, finally, the RDoC and the PDM-2, two western approaches that contrast with the DSM, which reflect different ends of the philosophical continuum, each share language that overlaps considerably with the DSM, and presuppose fluency with the DSM nosology. Further, both the RDoC model and the PDM-2 are also subject to criticisms, many of which are similar to criticisms levied against the DSM. In short, the DSM 5, like all diagnostic modalities, is an imperfect but necessary tool for training, practice, and professional fluency.

The Changing Structure of the DSM

In this section, you will be introduced briefly to the history of the DSM and then to the structure of the manual. This section will outline the structure of the diagnostic criteria tables as well as the DSM’s coding system.

Early Editions of the DSM. The first edition of the DSM, published in 1952, was written in a historical context in which psychoanalysis was the dominant therapeutic framework. Consequently, the first edition reflects this theoretical approach within its structure and language. Symptoms and diagnoses were divided into two primary categories: *Disorders Caused by or Associated with Impairment of Brain Tissue Function* (e.g., brain trauma or intoxication) and *Disorders of Psychogenic Origin or without Clearly Defined Physical Cause or Structural Change in the Brain*. Presentations of psychogenic origin were then divided into two subcategories: those that were described as “reactions” and those determined to be personality disorders. A personality disorder was

BOX 1.03 CONSIDER THIS: REFLECTION QUESTIONS

Professional ethics are built on a fabric of respect for clients and a prizing for cultural competency. At the same time, mental healthcare providers must be skilled in diagnostics.

- How will you maintain an awareness of these demands as you grow your knowledge and skills?
- What is your opinion of the role of diagnosis in the therapeutic relationship?
- Can clinicians diagnose without objectifying their clients?
- Do you see dangers in unconscious thought processes and cognitive bias, as Caplan and Cosgrove (2004) caution?
- What steps can you take to maintain a humanistic and multiculturally competent ethic in your practice while mastering diagnostic skills?

described as a life-long, “deeply ingrained maladaptive pattern of behavior” (p. 41). Reactions, on the other hand, described responses of the personality to any factor (biological, social or psychological). Put more simply, patients/clients were assigned a personality disorder when the presenting difficulties seemed to originate in the personality structure of the individual, were persistent and unlikely to change, while a reaction was attributed when the difficulty seemed to be a response to a stressor that was then expressed uniquely thanks to an individual’s own personality structure. The DSM II, published in 1968, began what would eventually end in a complete departure from the psychodynamic language, dropping terms like “reaction.” The structure of the manual remained largely the same.

A second distinction of the early editions of the DSM was their brevity. For example, the DSM II describes paranoid personality in a pithy 55 words while the DSM 5 discusses the same disorder in four pages. However, this brevity lent itself to wide variations in interpretation and misdiagnosis. For example, the only guidance offered in the DSM II for the diagnosis “occupational maladjustment” read as follows: “This category is for psychiatrically normal individuals who are grossly maladjusted in their work” (APA, 1968/2009, p. 52). Besides offering little guidance in what it means to be “psychiatrically normal,” the language offered in this description leaves a great deal of ambiguity around what one would describe as “maladjusted in their work” nor is guidance offered for how to differentiate maladjustment from “gross maladjustment.” Each successive edition of the DSM has worked to clarify ambiguous language within its definitions and criteria.

TABLE 1.01 Criticisms of the DSM 5 and Recommended Actions

Criticism	Recommended Action or Safeguard
<i>The lowering of diagnostic thresholds:</i>	<ul style="list-style-type: none"> Do not diagnose thoughts, feelings or behavior that appear to be normal responses to difficult situations: consider culture, gender and the range of typical behaviors (American Psychological Association, 2013) Defer diagnosis if symptoms have not been persistent or are in response to a crisis (American Psychological Association, 2013) Avoid diagnosis of developmentally expected behavior or responses (American Psychological Association, 2013)
<i>The inclusion of new diagnoses with little empirical support</i>	<ul style="list-style-type: none"> Use extreme caution with diagnoses newly added to the DSM 5 Consider alternative, better researched, and more common diagnoses where appropriate
<i>Theoretical orientation: embedded in biology: (medical model)</i>	<ul style="list-style-type: none"> Maintain a conceptual framework that takes into account sociocultural and relational influences on thoughts, feelings and behavior (Hays, 2008)
<i>Racism and Other Biases:</i>	<ul style="list-style-type: none"> When considering a diagnosis, be aware of vulnerable populations that may be susceptible to over or under diagnosis within each diagnostic dimension Consider your client's unique cultural context and its relationship to your client's complaints and symptoms (Hays, 2008) Consider areas of bias or lack of knowledge you may have as it relates to your client's cultural identities (Hays, 2008) Develop an awareness of one's own culture, worldview, blind spots, and biases (Hays, 2008) Carefully consider power differences between you and your client and work to level these power differences (Hays, 2008)
<i>Lack of clarity in diagnostic criteria:</i>	<ul style="list-style-type: none"> Use a conservative interpretation of the diagnostic criteria table when wording is unclear

Source: Adapted from American Psychiatric Association (2013) and Hays (2008).

DSM III-DSM IV-TR. The publication of the DSM III in 1980 marked a revision of both the structure of the manual as well as the framework on which it rests. Robert Spitzer led the DSM III and its task force in a movement that would ultimately lead to broader appeal of the DSM. The task force aimed to restructure the classification system so that it maintained compatibility with the ICD-9 and reflected the current knowledge of the field (a data focus) so that it might be “clinically useful” and also serve as a basis for research (APA, 1980, p. 2). In shifting emphasis to data and available research, the DSM III completed a shift from a psychodynamic theoretical

foundation, which had begun in the second edition, into an attempt to become atheoretical in its attribution of etiology. It is with the third edition that the DSM took on a medical model for understanding mental health concerns.

The organizational structure of the DSM also shifted so that disorders were placed in categories that contained disorders which shared symptoms (e.g., Schizophrenic Disorders, Affective Disorders, Somatic Disorders, Personality Disorders and so on). The definitions and criteria for each disorder were expanded and an effort was made to clarify what kind and how many symptoms were needed to diagnose a particular disorder in the hopes to increase inter-rater reliability and to provide a stronger foundation for research.

The DSM III-R, DSM IV and DSM IV-TR each made revisions to language and information with the continued aim of maintaining pace with the knowledge of the field but also adding diagnoses with each edition. While the DSM III fell just short of 500 pages, the DSM IV-TR had ballooned to well over 900 pages. The fifth edition of the DSM, however, is thought to mark the most significant revision of the model since its first printing. What follows are key features of the DSM 5.

The DSM 5 Structure and Its Revisions

The Dimensional System. The DSM 5 has shifted from a categorical framework to a dimensional system for organizing mental health concerns. Previous editions organized distinct disorders into distinct categories while the current DSM 5 takes the perspective that related disorders occupy a space along a dimension of difficulties that share signs and symptoms. Closely related dimensions are placed close together within the manual.

Chronological organization. Within each dimension, diagnoses are organized roughly in line with human lifespan development so that first to appear within a dimension are more typically observed earlier in life. Thus, a disorder like separation anxiety is listed before generalized anxiety since we are more likely to see separation anxiety disorder in children than in adults. Reflecting the developmental organization of the text, the neurodevelopmental disorders are listed at the opening of the manual, since these are evidenced in early childhood, and the neurocognitive disorders are listed at the back, as we typically see these closer to the end of life.

Diagnostic tables and their elements. Each chapter describing a diagnostic dimension opens with a list and brief description of the disorders contained within a given section. A diagnostic table is provided for each diagnosis that describes the criteria that must be met in order to make a diagnosis. The table often begins with a description of the disorder, and is followed by the *major criteria* marked with capital letters beginning with the letter “A” and varies from table to table as to how many major criteria follow. However, all diagnoses share descriptive criteria, generally the A criteria, an impairment criteria, since no diagnosis can be made if impairment is not present, and a rule out criteria that cautions the reader to consider other mental health

disorders, and medical health concerns or substances that might cause the symptoms described or observed. Most tables also include a duration criteria. Sub-criteria, are listed numerically under the A criteria, and less often the B and C major criteria. Tables vary a great deal in the number of major and sub-criteria listed within the table. For example, post-traumatic stress disorder lists major criteria A-H and contains a total of 24 sub-criteria, while circadian rhythm disorder lists only A-C and has no sub-criteria at all.

Specifiers. A specifier is a description that captures the distinct manifestations of a given disorder. Specifiers provide an avenue for noting severity, whether or not the current manifestation is the first occurrence of the disorder or a reemergence as well as the nature of symptoms that are present. Specifiers are unique to each disorder; some criteria tables contain many specifiers while others have none. When noting your diagnosis, include all specifiers that apply. It is important to note that for some disorders

BOX 1.04 WHEN SPECIFIERS INFLUENCE CODING

Joan and Antonio have each been diagnosed with a mild major depression. While this is Joan's first depressive episode, Antonio has a history of three episodes in the past 5 years. Note below how the coding of their disorders differs.

Joan: F32.0 Major depressive disorder, single episode, mild

Antonio: F33.0 Major depressive disorder, recurrent episode, mild

Try this: Using the table on page 162 of your DSM, recode Joan and Antonio's diagnoses assuming that Joan's episode is severe and Antonio's current episode is moderate.

BOX 1.05 CONSIDER THIS

Remember that the bolded codes in the DSM 5 criteria tables expired in October of 2015 and are no

longer used. All F codes should be checked against the current DSM supplements available online.

the specifier determines the diagnostic code. For example, consider two clients with a mild MDD, one client experiencing a first episode and the other experiencing a recurrence of his depression. In the following example, you will note that while each is experiencing the same disorder, the episode specifier has created a coding difference (find the specifier table for MDD on page 162 of the DSM 5):

The steps to coding and notation of a diagnosis as well as opportunities to practice this skill will be explained in Chapter 2, *Eight Steps to Diagnosis*.

Discussion. Each table is followed by a discussion of the presentation of the featured disorder in a section titled *Diagnostic Features*. This section is followed by a brief description outlining prevalence, a discussion of the development and course of the disorder, risks and prognostic factors, culture-related issues to be attuned to, gender concerns, functional impacts of the disorder, a list and discussion of alternate diagnoses, and, finally, the comorbidity rates. These sections often clarify vague or ambiguous descriptions within the diagnostic table and should be consulted carefully before diagnosis.

Coordination with the ICD-10 CM. In thumbing through the DSM 5, you will notice that each diagnostic table contains within it a code, and sometimes more than one code for each disorder. For example, on page 345 of the DSM 5, you will find the diagnostic table for Bulimia Nervosa. Beneath the name of the disorder, you will note a bolded code, **307.51**, and in a light grey font, within parentheses, F50.2. The bolded code in each table reflects the ICD-9 CM code and the grey code in parentheses, F50.2, reflects the ICD-10 CM code. The ICD-9 codes were to be used between the publication of the DSM 5 in 2013 and October 1, 2015, and should no longer be used in your coding or notation of disorders. The grey codes in parentheses reflect the revised ICD 10 CM codes. Since the publication of the ICD 11 in 2018 a sizable number of the ICD 10 codes have been updated and are now found in supplements to the DSM available as free downloads. It is worth noting that nearly all of the diagnoses contained in the DSM 5 begin with the letter F. In the current ICD structure,

BOX 1.06 THE USE OF Z CODES

Penny, 37, is homeless, unemployed and is currently sharing a space under a large overpass with her boyfriend, Mick. Mick has sometimes been violent with Penny and, since she has started counseling, has twice knocked her unconscious.

T74.11XD Partner violence, physical, confirmed, subsequent encounter
 Z59.0 Inadequate housing
 Z59.4 Lack of adequate food or safe drinking water
 Z59.5 Extreme poverty

“F” signifies a disorder that is mental, behavioral or neurodevelopmental in nature. Disorders are then further organized within number groupings.

Updates and Supplements to the DSM 5. The fifth edition of the DSM has been described as a “living document” and, in this spirit, periodic supplements are published on the American Psychiatric Association’s (APA) website. Though early revisions were offered in 2014, which went into effect in 2015, the first full supplement was published in September of 2016 and went into effect in October of the same year. Readers will want to remain aware that the DSM 5 will continue to undergo review and will incorporate changes to maintain alignment with future editions of the ICD. Consequently, further revisions will be forthcoming on the APA’s website at <http://dsm.psychiatryonline.org>. A benefit of these regular updates is the potential to create a document that is responsive to research and to clarifications from within the field. The drawback of this approach is the potential for clinicians to be working from different versions of the DSM 5, undermining one of the stated purposes of the DSM, which is to create a shared language and shorthand for disorders and to increase inter-rater reliability. Checking the APA website regularly for these updates and subscribing to APA announcements is advised.

Z codes. Often clients bring difficulties to psychotherapy that are not themselves disorders but are the focus of a client’s work. For example, a client who is rebuilding her life after leaving an abusive relationship will likely want to focus on the experience of the abuse as a part of her therapeutic process. Concerns that are the focus of clinical work but are not disorders are categorized and coded within the “Z codes” (previously “V codes”) located in the back of the DSM 5, pages 715-727, in a section titled *Other Conditions that May be a Focus of Clinical Attention*.

In Box 1.06 note that the clinician is working with a client who has come to a local free clinic where she can receive counseling and other services. Note how the clinician has made use of Z codes to convey her client’s current struggles more fully.

Conclusion

In this chapter, we have explored together the purpose of diagnostic nosology and the DSM 5 in particular. We have been briefly introduced to a few alternative approaches including the widely used ICD and emergent models, such as the RDoC, and have even touched upon a non-Western approach to conceptualizing mental health concerns. We have explored the basic structure of the DSM and its major criticisms and have explored some avenues for reducing the risks posed by the shortcomings of the manual.

Unfortunately, it is not enough to be able to find one’s way around the DSM 5, indeed, a great deal of work and thought must be undertaken between the time when a clinician meets with a client for the first time and is ready to make a note of a diagnosis. In Chapter 2, you will be introduced to eight steps to arriving at a sound clinical

diagnosis as well as 10 guiding diagnostic principles. Together, the eight steps and 10 principles will offer structure and guidance through the often challenging and complex process of clinical diagnosis.

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