

Deconstructing the DSM-5

By Jason H. King

Understanding and using the DSM-5

I recognize that many counselors have anxiety about using the newly released fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), especially because it no longer requires use of the DSM-IV multi-axial system. For this month's article, I would like to focus on this, and other important changes, in an effort to help counselors feel more comfortable in using the DSM-5.

My recommendation as counselors begin using the DSM-5 is to first read Section I: DSM-5 Basics (introduction, use of the manual and cautionary statement for forensic use of the DSM-5). Second, read "Highlights of Changes From DSM-IV to DSM-5" in the appendix and, third, read Section II: Diagnostic Criteria and Codes. I am confident that if you read the DSM-5 in this order, you will better understand the new organizational changes and the expanded conceptualization of mental disorders.

I consider Section I to be a "gold nugget" of helpful information that greatly assists with my general orientation to the new diagnostic landscape. In the introductory chapter, you are provided with a brief history of the DSM-5, aspects of the DSM-5 revision process, the new organizational structure, how culture issues and gender differences affect diagnostic practice, correct use of other specified and unspecified disorders, and the rationale for elimination of the multi-axial system. In addition, you are given direction on accessing online enhancements, such as assessment measures and insurance implications.

As I read this chapter, I learned that the DSM-5 classification system is meant to stimulate new clinical perspectives — just as I encourage my clients to develop new perspectives in their lives. "New clinical perspectives" means that I challenge the status quo, critically analyze client symptoms and am open to cognitive dissonance within myself.

As you read this chapter, you will also learn about the new clustering of disorders presented in a framework of "internalizing" factors (anxiety, depression and somatic symptoms) and "externalizing" factors (impulsive, disruptive and addictive symptoms) that influence clinical formulation.

Most important, you will understand the new developmental and life span considerations that organize disorders in a framework beginning with those that occur in early life (neurodevelopmental and schizophrenia spectrum and other psychotic disorders).

This is followed by disorders that occur in adolescence and young adulthood (depressive, bipolar and anxiety disorders) and ends with diagnoses more relevant to adulthood and later life (personality disorders and neurocognitive disorders).

Moving to the next chapter on use of the manual, you will read about important guidelines to approach clinical case formulation. This chapter discusses the need to obtain a “careful clinical client history and concise summary” surrounding client biopsychosocial factors. I appreciate the DSM-5’s focus on my need for clinical judgment, clinical training and the importance of developing contextual and comprehensive treatment plans that are influenced by my client’s cultural and social context.

This chapter also provides the new definition of “mental disorder” that focuses on clinically significant disturbances, developmental processes, culturally approved responses and socially deviant behavior (see page 20). This definition links disorders and broadens their conceptualization on the basis of common neurocircuitry, genetic vulnerability and environmental exposures. With this new definition, the DSM-5 encourages me to use “clinical utility” to help determine client prognosis, develop sensitive treatment plans and measure treatment outcomes.

Those familiar with the DSM-IV will find additional discussion on the greatly expanded elements of a diagnosis (there are more than 130 from which to choose), such as severity specifiers, descriptive specifiers and course specifiers. Subtypes are used in the DSM-5 as a method to communicate mutually exclusive symptom presentations. Counselors will still list the principal diagnosis first and use provisional diagnosis to indicate diagnostic uncertainty.

A new and important change for counselors is the DSM-5’s use of “dimensional” rather than multiaxial assessment (see pages 12-13), in which DSM-5 combines the first three DSM-IV axes. The DSM-IV provided us an important reminder that “the multiaxial distinction among Axis I, Axis II, and Axis III disorders does not imply that there are fundamental differences in their conceptualization, that mental disorders are unrelated to physical or biological factors or processes, or that general medical conditions are unrelated to behavioral or psychosocial factors or processes.”

Unfortunately, too many professionals using the DSM-IV developed an artificial culture of diagnostic hierarchy that stifled clinical utility. As such, and to align with the World Health Organization’s (WHO’s) International Classification of Diseases (ICD), the DSM-5 replaces the axis concept with a dimensional concept when communicating disorders to other professionals and to third-party payers (see pages 16-17).

Sample DSM-5 diagnosis

Consider the following notional diagnosis for a client we shall call Robert:

V62.21 Problem Related to Current Military Deployment Status
301.89 Other Specified Personality Disorder (mixed personality features — dependent and avoidant symptoms)
327.26 Comorbid Sleep-Related Hypoventilation
300.4 Persistent Depressive Disorder (Dysthymia), With anxious distress, In partial remission, Early onset, With pure dysthymic syndrome, Moderate

V62.89 Victim of Crime
278.00 Overweight or Obesity
WHODAS: 63

Please note some important aspects to this new dimensional diagnostic listing. First, I listed the V-code because this is the principal reason for Robert entering treatment — he was recently placed on inactive duty for repeated physical assaults of other personnel (see pages 22-23). The contributing psychosocial and environmental factors or other reasons for treatment are now represented through an expanded set of ICD-9 V-codes and, from the forthcoming ICD-10, Z-codes (see pages 715-727).

Second, personality testing at Robert's admission indicated some significant characterological features that warrant clinical attention. Note that I used "other specified" rather than "not otherwise specified" (as commonly used with the DSM-IV) and that I listed the specific and identifiable personality characteristics to communicate to others what I was detecting in Robert (the DSM-5 requires this procedure; see pages 15-16).

Third, I listed the new DSM-5 sleep-wake disorder diagnosis as obtained from Robert's medical records (he received independent sleep study testing that determined this diagnosis).

Fourth, I listed the DSM-5's new name for dysthymic disorder and included multiple specifiers as required by the DSM-5. This communicates more diagnostic specificity to improve clinical utility and treatment planning (see pages 20-21). "With anxious distress" is a descriptive specifier. "In partial remission" is a course specifier. "Early onset" is also a course specifier. "With pure dysthymic syndrome" is a descriptive specifier, and "Moderate" is a severity specifier.

Fifth, I noted Robert's recent victimization, having had personal belongings stolen from him while deployed. This is another condition that may be a focus of clinical attention (see page 725).

Sixth, Robert's nonadherence to prescribed medical treatment is indicated by noting his co-occurring obesity issue (see page 726).

Seventh, Robert's separate measures of symptom severity and disability are indicated with use of the WHO's Disability Assessment Schedule (WHODAS), which replaces the DSM-IV's Global Assessment of Functioning (see pages 16 and 745-748). This change is consistent with WHO recommendations to move toward a clear conceptual distinction between disorders contained in the ICD and the disabilities resulting from disorders, which are described in the International Classification of Functioning, Disability, and Health (ICF).

The WHODAS measures six client domains:

- Cognition: Understanding and communication
- Mobility: Moving and getting around
- Self-care: Hygiene, dressing, eating and staying alone

- Getting along: Interacting with other people
- Life activities: Domestic responsibilities, leisure, work and school
- Participation: Joining in community activities.

You can download this assessment protocol at who.int/classifications/icf/whodasii/en/ and learn more about its associated psychometric properties. The WHODAS is provided in Section III of the DSM-5 as the best current alternative for measuring disability. Various disorder-specific severity scales are also included in Section III and online.

While in Section III, be sure to read up on the DSM-5's expanded Cultural Formulation Interview (CFI, see pages 749-759). In the CFI, culture refers primarily to the values, orientations and assumptions that individuals derive from membership in diverse social groups (for example, ethnic groups, the military and faith communities), which may conform or differ from medical explanations.

The CFI offers 14 questions that counselors can use during a mental health assessment to obtain information about the impact of culture on key aspects of care. These domains include cultural definition of the problem; cultural perceptions of cause, context and support; cultural factors affecting self-coping; past help seeking; and current help seeking.

The CFI helps counselors to develop strategies for adapting counseling theories, techniques and interventions to meet the needs of diverse clients and to use multicultural competencies and strategies for working with and advocating for diverse populations.

Overall, notice that with the DSM-5, personality disorder diagnoses (Axis II in the DSM-IV) can supersede the traditional Axis I disorders listed in the DSM-5, and V-codes (soon to be Z-codes in October 2014) can also supersede traditional DSM-IV Axis I, Axis II and Axis III disorders. The rationale for this recording procedure is to dismantle artificial boundaries between disorders so as to promote treatment outcome-oriented care.

I find the DSM-5 adheres well to the Council for Accreditation of Counseling and Related Educational Program's proposed 2016 assessment standards related to methods of effectively conducting initial intake and informal assessments, procedures for assessing suicide and violence risk, and use of informal assessments for diagnostic purposes to effectively diagnose developmental, behavioral and mental disorders.

Important recommendations

Earlier, I suggested three important sequences of reading as you begin your use of the DSM-5. I also strongly encourage you to read the rich textual description provided for each disorder. This narrative includes a discussion on diagnostic content, diagnostic features, associated features, prevalence, development and course, risk and prognostic factors, environmental/genetic/physiological/temperamental factors, course modifiers, culture-related diagnostic issues, gender-related diagnostic issues, suicide risk, diagnostic content, functional consequences, differential diagnosis, comorbidity, subtypes and specifiers for each disorder.

In reading each of these aspects related to a disorder, you will become more adept at using the DSM-5 and display advanced clinical formulation abilities. It is also advisable to carefully read each coding note as well as coding and reporting procedures for each disorder.

As you shift from using the DSM-IV to the DSM-5, remember that the DSM-5 is intended to serve as a practical, functional and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. The overarching goal of the DSM-5 is to promote diagnostic specificity, treatment sensitivity and case formulation.

I also encourage you to recognize the limitations of using the DSM-5 in forensic settings. The manual is not designed for nonclinical professionals and does not meet the technical needs of the courts and legal professionals (see page 25).

When using the DSM-5, it is not sufficient to simply check off the symptoms in the diagnostic criteria to make a diagnosis. Proper use of the manual requires clinical training to recognize when signs and symptoms exceed normal ranges.

Some additional reminders that I offer:

- Diagnoses incorporate sensitivity to age, gender and culture-specific factors.
- Diagnoses are guidelines for understanding human behaviors.
- Diagnoses are not intended to be considered as legal definitions for use by law enforcement and the courts.
- Disorders should not be an expected or culturally sanctioned response to a particular event.
- Disorders are conditions that people have, but they do not define the person.
- Disorders are quite often early life coping or defense mechanisms that are now seen as dysfunctional and causing distress in adult life.

In conclusion, I strongly recommend reading K. Dayle Jones' article "Dimensional and Cross-Cutting Assessment in the DSM-5," published in the October 2012 Journal of Counseling & Development. She aptly discussed the problems with the DSM-IV classification system, the excessive use of co-occurring disorders and the excessive use of not otherwise specified categories, while providing a better understanding of the new DSM-5 dimensional and cross-cutting assessment procedures and their implications for clinical utility and user acceptability. Best to you!

Bio

Jason H. King is core faculty in the CACREP-accredited mental health counseling program at Walden University. He is a state-licensed and national board certified clinical mental health counselor and an AMHCA diplomate and clinical mental health specialist in substance abuse and co-occurring disorders counseling. He received the 2012 AMHCA Mental Health Counselor of the Year Award. He provides face-to-face and video trainings on the DSM-5. Contact him at jking@mellivoragroup.com.
Letters to the editor: ct@counseling.org