

Clinical Application of the *DSM-5* in Private Counseling Practice



The Professional Counselor
Volume 4, Issue 3, Pages 202–215
<http://tpcjournal.nbcc.org>
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doi:10.15241/jhk.4.3.202

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013)* continues its 60-year legacy as a standard reference for clinical practice in the mental health field. Six mental health disorders are reviewed with a focus on changes between the *DSM-IV-TR* and the *DSM-5* that represent the new landscape for each of these disorders, respectively. Following the summary of changes, a clinical scenario is presented so that counselors can capture the vision of using the *DSM-5* in their counseling practice. Clinical formulation (sample diagnosis) using the *DSM-5* is also presented for each disorder classification.

Keywords: *DSM-5*, *DSM-IV-TR*, private practice, clinical formulation, mental disorders

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013)* continues its 60-year legacy as a standard reference for clinical practice in the mental health field. This practical, functional and flexible guide is intended for use by trained counselors in a wide diversity of contexts and facilitates a common language to communicate the necessary characteristics of mental disorders present in their clients (APA, 2013). As counselors use the *DSM-5*, they will notice an expanded discussion of developmental and life span considerations, cultural issues, gender differences, integration of scientific findings from the latest research in genetics and neuroimaging, and enhanced use of course, descriptive and severity specifiers for diagnostic precision (APA, 2013). They will also notice a dimensional approach to diagnosis, consolidation and restructuring of most mental disorders; a new definition of a mental disorder; and emerging assessments and monitoring tools so as to promote enhanced clinical case formulation.

The intent of this article is to assist all counseling specialists by presenting six clinical scenarios from the author's counseling practice. The article begins by summarizing the clinical utility of the *DSM-5* and provides recommendations for counselors on how to sequence their study of the new manual. Discussed next are use of the new emerging assessment measures, autism spectrum disorder, schizophrenia spectrum and other psychotic disorders, sleep-wake disorders, neurocognitive disorders, and comorbid conditions such as excoriation (skin-picking) disorder and post-traumatic stress disorder—with a focus on prominent changes between the *DSM-IV-TR* and the *DSM-5*. Clinical formulation and its associated rationale using the *DSM-5* are presented for each disorder classification.

Counselors are encouraged to read the full manual and to especially read the Preface; Section I (i.e., Introduction, Use of the Manual, and Cautionary Statement for Forensic Use of *DSM-5*); Section III: Emerging Measures and Models (i.e., Assessment Measures); and Appendix (i.e., Highlights of Changes From *DSM-IV* to *DSM-5*) before they attempt applied clinical use of the manual. To appreciate the rationale for the *DSM-5* changes, counselors are encouraged to read the *DSM-IV-TR* discussion on limitations to the categorical approach (APA, 2000, pp. xxxi–xxxii) and on the nonaxial format (p. 37). This sequencing of study will help

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counselors use the manual as intended and avoid diagnostic errors, as well as maintain cultural sensitivity and avoid historical and social prejudices in the diagnosis of pathology (ACA, 2014).

Cross-Cutting Symptom Measures and Disorder-Specific Severity Measures

Clinicians are to administer emerging assessment measures at the initial interview and to monitor treatment progress, thus serving to promote the use of initial symptomatic status and reported outcome information (APA, 2013). The *DSM-5* cross-cutting symptom measures support comprehensive assessment by drawing attention to clinical symptoms that manifest across diagnoses. Cross-cutting symptom measures have two levels. Level 1 measures offer a brief screening of 13 domains for adults (i.e., depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use) and 12 domains for children and adolescents (i.e., depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use). Level 2 measures provide a more in-depth assessment of elevated Level 1 domains to facilitate differential diagnosis and determine severity of symptom manifestation. The *DSM-5* disorder-specific severity measures correspond closely to the criteria that constitute the disorder definition and are intended to illuminate additional areas of inquiry that may guide treatment and prognosis (APA, 2013; Jones, 2012). Counselors can access these no-cost assessment measures at <http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures>. The *DSM-5* provides counselors with further information on the background and reasoning for use of these emerging measures in clinical practice (see pp. 733–748).

Autism Spectrum Disorder

The New Landscape

From as early as 1993, authors and researchers have referred to the various pervasive developmental disorders as *autism spectrum disorder* (Rutter & Schopler, 1992; Shuster, 2012; Tanguay, Robertson, & Derrick, 1998). They have also called for use of a dimensional rather than a categorical classification as used in *DSM-IV* and *DSM-IV-TR* (Kamp-Becker et al., 2010). Unlike the dichotomous approach of the *DSM-IV-TR* categorical model, the dimensional approach uses three or more rating scales to measure severity, intensity, frequency, duration or other characteristics of given diagnoses (Jones, 2012). Consensus in the research community for a spectrum classification is clearly demonstrated in that 95% of publications in the past 5 years have used the term “autism spectrum disorder.” Hence, the *DSM-5* uses the term *spectrum* and further informs counselors that “autism spectrum disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner’s autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger’s disorder” (APA, 2013, p. 53). Consolidating use of these dichotomous autism-based titles into a spectrum designation helps to avoid diagnostic confusion and to minimize fragmented treatment planning.

Based on factor structure models, the *DSM-5* presents a major reconceptualization and reorganization of the *DSM-IV-TR* autistic disorder symptomatology (Guthrie, Swineford, Wetherby, & Lord, 2013). This new spectrum, or dimensional classification, helps counselors to properly assess deficits in social-emotional reciprocity (i.e., the inability to engage with others and share thoughts and feelings); nonverbal communicative behaviors used for social interaction (i.e., absent, reduced or atypical use of eye contact [relative to cultural norms], gestures, facial expressions, body orientation or speech intonation); ability to develop, maintain and understand relationships (i.e., absent, reduced or atypical social interest, manifested by rejection of others, passivity or inappropriate approaches that seem aggressive or disruptive); and marked presentations

of restricted, repetitive patterns of behavior, interests or activities. This reconceptualization of autism in the *DSM-5* provides counselors with a denser diagnostic cluster to reduce excessive application of the *DSM-IV-TR pervasive developmental disorder not otherwise specified* classification that resulted in overdiagnosis and concerning prevalence rates (Maenner et al., 2014).

The *DSM-5* further recognizes autism due to Rett syndrome, Fragile X syndrome, Down syndrome, epilepsy, valproate, fetal alcohol syndrome or very low birth weight through use of the specifier *associated with a known medical or genetic condition or environmental factor*. Counselors also may use the specifiers *with or without accompanying intellectual impairment* and *with or without accompanying language impairment*. Examples of descriptive specifier usage include *with accompanying language impairment—no intelligible speech* or *with accompanying language impairment—phrase speech*. If catatonia is present, counselors record that separately as *catatonia associated with autism spectrum disorder*. Severity, or intensity of symptoms, for autism spectrum disorder are now communicated on three levels: *Level 1 mild requiring support*, *level 2 moderate requiring substantial support*, and *level 3 severe requiring very substantial support* (APA, 2013).

The level of interference in functioning and support required is communicated by using the *DSM-5* Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders scale (APA, 2013, p. 52). Examples of *mild* rating in the social communication psychopathological domain may include the following: without supports in place, deficits in social communication cause noticeable impairments; has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others; and may appear to have decreased interest in social interactions. Examples of *mild* rating in the restricted interests and repetitive behaviors psychopathological domain may include rituals and repetitive behaviors (RRBs) that cause significant interference with functioning in one or more contexts, or resists attempts by others to interrupt RRBs or to be redirected from fixated interest (APA, 2013).

Examples of *moderate* rating in the social communication psychopathological domain may include marked deficits in verbal and nonverbal social communication skills, social impairments apparent even with supports in place, limited initiation of social interactions, and reduced or abnormal response to social overtures from others. Examples of *moderate* rating in the restricted interests and repetitive behaviors psychopathological domain may include RRBs and/or preoccupations and/or fixated interests that appear frequently enough to be obvious to the casual observer and inhibit functioning in a variety of contexts. Frustration or distress is apparent when RRBs are interrupted; it is difficult to redirect attention from fixated interest (APA, 2013).

Examples of *severe* rating in the social communication psychopathological domain may include severe deficits in verbal and nonverbal social communication skills that cause significant impairments in functioning, very limited initiation of social interactions, and minimal response to social advances from others. Examples of *severe* rating in the restricted interests and repetitive behaviors psychopathological domain may include preoccupations, fixed rituals and/or repetitive behaviors that significantly interfere with functioning in all domains; distinct distress when rituals or routines are interrupted; difficulty redirecting from fixated interest or returns to it quickly. Counselors are advised to review Table 2 Severity Levels for Autism Spectrum Disorder displayed in the *DSM-5* (APA, 2013, p. 52).

Clinical Scenario

Walter, a 22-year-old male, was referred to counseling by the State Office of Rehabilitation for career and vocational assistance, with a special focus on his mental health needs and confirming the presence of his previous diagnosis of Asperger's disorder given in 2004. Counselors working with adults presenting with autism spectrum symptoms will appreciate the *DSM-5's* new adult textual narrative. Some of these additions help to understand adults like Walter, who:

- Must show persistent symptoms from early childhood across multiple contexts;
- Display difficulties processing and responding to complex social cues;
- Suffer from anxiety because of purposefully calculating what is socially intuitive for other adults;
- Express difficulty in coordinating nonverbal communication with speech;
- Struggle to comprehend what behavior is considered appropriate in one situation but not another; and
- Learn to suppress repetitive behavior in public.

Following assessment procedures outlined in the *DSM-5* to use “standardized behavioral diagnostic instruments with good psychometric properties, including caregiver interview, questionnaires and clinician observation measures” (APA, 2013, p. 55) and by Jones (2010), clinical assessment of Walter included the following:

- Biopsychosocial clinical interview of Walter with his mother as an additional informant
- Level 1 Cross-Cutting Symptom Measure (see APA, 2013, pp. 733–744 or www.psychiatry.org/dsm5)
- The Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders (see APA, 2013, p. 52 or www.psychiatry.org/dsm5)
- Historical evaluations (prior psychological testing results)
- Collateral reports from the referring vocational rehabilitation counselor
- Simon Baron-Cohen’s Autism Spectrum Quotient (Baron-Cohen, Wheelwright, Skinner, Martin, & Clubley, 2001; Ketelaars et al., 2008)

Adhering to *DSM-5* dimensional rather than *DSM-IV-TR* multi-axial classification (Jones 2012), Walter was diagnosed using this format:

299.00 Autism spectrum disorder; requiring substantial support for social communication and social interaction (level 2 moderate); requiring support for restricted repetitive behaviors, interests and activities (level 1 mild); without accompanying intellectual impairment; without accompanying language impairment; without catatonia.

Notice the diagnostic precision offered by the *DSM-5* in comparison with Walter’s non-descriptive diagnosis using the *DSM-IV-TR* formulation: Asperger’s Disorder (APA, 2000). In contrast, the severity ratings for autism spectrum disorder are listed independently for social communication and restricted repetitive behaviors, rather than providing a global rating for both psychopathological domains (per the *DSM-5* they are listed from most severe to least severe). For Walter, his moderate severity rating of *requiring substantial support* for social communication means: “Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others” (APA, 2013, p. 52). His mild severity rating of *requiring support* for restricted repetitive behaviors (RRBs) means: “Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence” (APA, 2013, p. 52). The diagnostic formulation offered to counselors in the *DSM-5* provides a richer contextual description of the client to support more personalized treatment planning. This attention to dimensional ratings and individualized treatment strategies is also captured in the newly conceptualized schizophrenia spectrum disorders.

Schizophrenia Spectrum and Other Psychotic Disorders

The New Landscape

Counseling clients presenting with psychotic and schizophrenia spectrum disorders is challenging and diagnostically complex. To assist with these difficulties, the *DSM-5* presents a new conceptualization to

facilitate clinical utility and to streamline diagnostic formulations (Bruijnzeel & Tandon, 2011). Similar to autism, schizophrenia has been referenced as a *spectrum disorder* since 1995 (Kendler, Neale, & Walsh, 1995) and the *DSM-5* marks the official recognition of this spectrum conceptualization by embedding the word in the diagnostic title. Essential to competent practice in this area is reading the section on key features that define the psychotic disorders on pages 87–88 of the *DSM-5* (APA, 2013; e.g., delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms). Further critical reading is the new Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis on the *DSM-5* pages 89–90 (APA, 2013). These pages describe the heterogeneity of psychotic disorders and the dimensional framework for the assessment of primary symptom severity within the psychotic disorders. This spectrum conceptualization differs from the *DSM-IV-TR* categorical and mutually exclusive diagnostic system that assumed “mental disorders are discrete entities, with relatively homogeneous populations that display similar symptoms and attributes of a disorder” (Jones, 2012, p. 481).

The new Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS) is used to understand the personal experience of the client, to promote individualized treatment planning, and to facilitate prognostic decision making (Flanagan et al., 2012; Heckers et al. 2013). Counselors can obtain the CRDPSS in the *DSM-5* pages 742–744 (APA, 2013) or www.psychiatry.org/dsm5. The CRDPSS is an eight-item measure used to assess the severity of mental health symptoms that are important across psychotic disorders. These symptoms include delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms (i.e., restricted emotional expression or avolition), impaired cognition, depression and mania. Psychosis symptoms are rated on a five-point scale: not present, equivocal (severity or duration not sufficient to be considered psychosis), mild (little pressure to act, not very bothered by symptoms), moderate (some pressure to respond or somewhat bothered by symptoms) and severe (severe pressure to respond to voices or very bothered by voices).

According to the *DSM-5*, proper use of the CRDPSS may include clinical neuropsychological assessment (especially of client cognitive functioning) to help guide diagnosis and treatment. Counselor “assessment of [client] cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders” (APA, 2013, p. 98). Depending on the stability of client symptoms and treatment status, the CRDPSS may be completed at regular intervals as clinically indicated to track changes in client symptom severity over time. Consistently high scores on a specific domain may indicate significant and problematic areas for the client that may warrant further assessment (mental status examination), treatment (counseling and pharmacological), and follow-up (case management).

In the *DSM-5*, delusional disorder is retained as listed in *DSM-IV-TR*, including its classic subtypes of erotomanic, grandiose, jealous, persecutory and somatic. Some textual updates occur in the *DSM-5* for brief psychotic disorder that place emphasis on disorganized or catatonic behavior. Schizophreniform disorder in the *DSM-5* parallels the description in the *DSM-IV-TR*. Diagnostic precision for schizophrenia in the *DSM-5* is communicated with new course specifiers that can “be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria” (APA, 2013, p. 99). These new course specifiers communicate a time period in which the symptom criteria are fulfilled (acute), a period of time during which improvement after a previous episode is maintained and in which the defining criteria of the disorder are only somewhat fulfilled (partial remission), or a period of time after a prior episode during which no disorder-specific symptoms are present (full remission). Counselors also can communicate these specifiers based on first episode, multiple episodes, continuous episodes or unspecified. Use of these specifiers assists counselors in determining the intensity, frequency and duration of clinical intervention services that are more person-centered.

To align with a dimensional, or spectrum paradigm, the categorical *DSM-IV-TR* schizophrenia subtypes (i.e., paranoid type, disorganized type, catatonic type, undifferentiated type and residual type) are not used in the *DSM-5* because they are included in the previously described CRDPSS. Research also does not support the use of the subtypes and does not indicate any qualitative differences between the subtypes that impact treatment planning or symptom presentation (Tandon et al., 2013). Catatonia, a syndrome of disturbed motor, mood and systemic signs, becomes a specifier in the *DSM-5*, applicable for neurodevelopmental, depressive, bipolar and all psychotic disorders (APA, 2013). Unlike the *DSM-IV-TR*, the *DSM-5* does not contain the following exception clause to diagnose schizophrenia: “Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the persons’ behavior or thoughts, or two or more voices conversing with each other” (APA, 2000, p. 312). Removal of this language restricts classification to avoid excessive classification in nonclinical profiles, thus promoting ethical practice (ACA, 2014).

Although the *DSM-5* acknowledges that “there is growing evidence that schizoaffective disorder is not a distinct nosological category” (APA, 2013, pp. 89–90; see also Malaspina et al., 2013), this disorder is retained, with some textual refinements to more stringently define the clinical syndrome. These changes include the following: criterion B: “lifetime duration of the illness” (APA, 2013, p. 105); and criterion C: major mood episode must be “present for the majority of the total duration for the active and residual portion of the illness” (APA, 2013, p. 105) instead of the *DSM-IV-TR*’s focus on substantial portion for the active and residual portion of the illness.

Clinical Scenario

Ryan, a 22-year-old Caucasian male, presented with an extensive history of auditory hallucinations and erotomantic and paranoid delusions. In the spirit of the *DSM-5*, he was administered the CRDPSS six times, beginning with the onset of counseling and then at various counseling sessions during his treatment. Use of the CRDPSS promotes clinical utility. For example, Ryan is able to identify trends and patterns related to life stressors and symptom elevations and reductions. This level of clinical assessment provides a framework for targeted treatment planning and clinical intervention. Ryan also feels empowered over his mental illness and obtains a more positive perspective regarding his self-efficacy with coping skills to manage his psychotic symptoms. Most importantly, the CRDPSS encourages measurement-based care in the burgeoning era of practice-based evidence requirements (Tandon et al., 2013). Adhering to the *DSM-5* dimensional classification, I diagnosed Ryan using this format:

295.70 Schizoaffective disorder, bipolar type, severe hallucinations, moderate delusions (erotomantic and persecutory), moderate abnormal psychomotor behavior, moderate negative symptoms, equivocal disorganized speech, continuous episode, currently in partial remission, without catatonia.

Compare the *DSM-5* clinical formulation to the *DSM-IV-TR* diagnostic formulation:

295.70 Schizoaffective disorder, bipolar type.

The *DSM-5* diagnostic conceptualization offers a contextualized framework in “developing a comprehensive treatment plan that is informed by the individual’s cultural and social context” (APA, 2013, p. 19) by rating primary symptoms of psychosis in order of severity so as to promote prognostic decision-making. This level of diagnostic specificity also is found in the *DSM-5* sleep-wake disorders.

Sleep-Wake Disorders

The New Landscape

Sleep-wake disorders in the *DSM-5* represent a radical revamping of diagnostic syndromes, clinical conceptualization and specifier annotations. This is because the “*DSM-IV* was prepared for use by mental health and general medical clinicians who are not experts in sleep medicine” (APA, 2013, p. 362). Grounded in the current International Classification of Sleep Disorders, 2nd edition (*ICSD-2*), the *DSM-5* sleep-wake disorders work group used this classification system as a benchmark for diagnostic revision. When counselors read each sleep-wake disorder in the *DSM-5*, they will discover that a note about relationship to the *ICSD* is presented. Because of the new sleep-wake disorder conceptualization and the dimensional (instead of categorical) formulation of mental disorders in the *DSM-5*, counselors are to use the emerging measures for sleep-wake disorders for children and adults located at www.psychiatry.org/dsm5.

As counselors read the sleep-wake disorders chapter in the *DSM-5*, they will notice an increased emphasis on a multidimensional approach to assessment that includes medical examination, such as the use of polysomnography, quantitative electroencephalographic analysis and testing for hypocretin (orexin) deficiency (APA, 2013). They will also notice a greater emphasis on the dynamic relationship between sleep-wake disorders and certain mental or medical conditions, and that pediatric and developmental criteria and the general text are integrated based on existing neurobiological and genetic evidence and biological validators (Kaplan, 2013). The *DSM-5* sleep-wake disorders textual descriptors use the terminology “coexisting with” or “comorbidity” instead of the *DSM-IV-TR* “related to” or “due to.” Sleep-wake disorders in the *DSM-5* further provide diagnostic precision by offering use of course specifiers (i.e., episodic, persistent, recurrent, acute, subacute), descriptive specifiers (i.e., with mental disorder, with medical condition, with another sleep disorder), and severity specifiers (i.e., mild, moderate, severe).

The insomnia-based sleep-wake disorders focus on problems with initiating or maintaining quality sleep. Some of these disorders preclude assessment by a counselor, as they require examination by a sleep medicine expert. The *DSM-IV-TR* primary insomnia and insomnia related to another mental disorder are merged in the *DSM-5* to become insomnia disorder. The *DSM-IV-TR* primary hypersomnia and hypersomnia related to another mental disorder are merged to become the *DSM-5* hypersomnolence disorder. Narcolepsy is retained in the *DSM-5* with substantial symptom description changes, five new specifiers and requirements for sleep medicine examination to confirm a diagnosis. Narcolepsy now requires either the presence of cataplexy (sudden loss of muscle tone), hypocretin deficiency as measured using cerebrospinal fluid, or REM sleep latency deficiency as measured using polysomnography (APA, 2013). Breathing-related sleep disorders in the *DSM-5* include obstructive sleep apnea hypopnea, central sleep apnea (new for the manual) and sleep-related hypoventilation (new for the manual). Circadian rhythm sleep-wake disorders in the *DSM-5* no longer recognize jet lag, resulting in five types (i.e., delayed sleep phase, advanced sleep phase, irregular sleep-wake, non-24-hour sleep-wake and shift work) for counselors to select when diagnosing this syndrome. Parasomnias, defined as abnormal behavior or physiological events during sleep, also are reconceptualized in the *DSM-5*. The *DSM-IV-TR* sleepwalking disorder and sleep terror disorder are merged to become the *DSM-5* non-rapid eye movement sleep arousal disorder, with sleepwalking type, sleep-related eating, sleep-related sexual behavior, and sleep terror type specifiers (APA, 2013). Nightmare disorder is retained with no substantial changes from the *DSM-IV-TR*. The *DSM-IV-TR* parasomnia not otherwise specified is renamed in the *DSM-5* to rapid eye movement sleep behavior disorder for disruptive dream enacting behaviors, and *DSM-IV-TR* dyssomnia not otherwise specified is renamed in the *DSM-5* to restless legs syndrome.

Clinical Scenario

Jasmine, a 36-year-old Caucasian female, is married and has four children. She reported a history of major depression (with two to three episodes of intense suicidal ideation) and generalized anxiety disorder. Results from the World Health Organization's *Adult ADHD Self-Report Scales* (Kessler et al., 2004) indicated possible attention-deficit/hyperactivity disorder combined presentation. Results from the psychometric *Conners' Continuous Performance Test II* confirmed the presence of a mild to moderate ADHD combined presentation profile. Despite pharmacological (both prescription and over the counter) and psychological (sleep hygiene and behavioral-focused) interventions, Jasmine continued to report daytime sleepiness, fatigue and unrefreshing sleep throughout the week, lasting for many months. This produced functional impairment with employment obligations and interpersonal relationships.

In the spirit of the *DSM-5* and in collaboration with her general practitioner, Jasmine was referred to a local sleep medicine clinic to receive formal sleep-wake disorder testing (polysomnography). This was done to confirm the presence of an independent sleep-wake disorder not better accounted for by her depression and anxiety disorders. The resulting sleep-wake study report included the following excerpts:

This is 36-year-old female patient with a past medical history that is remarkable for gastric reflux, allergies and asthma. Patient is overweight with a BMI (body mass index) of 26.31. There is a longstanding history of: frequent awakenings, use of sleeping pills, frequent difficulty waking up, nonrestorative sleep, excessive daytime sleepiness, nasal congestion, frequent loud snoring, palpitations, night sweats and waking up with muscle paralysis. Patient complains of excessive daytime sleepiness with an Epworth Sleepiness score that is abnormal at 14 out of 24. Total sleep time is adequate at 8 hours per night. Patient denies smoking and drinking alcohol. Current medications include: Pantoprazole, Simvastatin, Amitriptyline, Loratadine and Fluticasone. As such, an overnight sleep study was ordered for evaluation of an underlying sleep-related breathing disorder.

Interpretation:

- Obstructive apneas (suspension of external breathing) of 17.1/hour associated with oxygen desaturation to as low as 72%. This is consistent with the diagnosis of moderate Obstructive Sleep Apnea.
- Sleep-related hypoventilation/hypoxemia due to sleep apnea is present.
- Severe initial insomnia.

Recommendations:

- Continuous positive airway pressure (CPAP) therapy should be offered to this patient given the risk of stroke and the significant daytime sleepiness. As such, a second overnight sleep study for CPAP titration is strongly recommended. If daytime sleepiness persists despite adequate CPAP therapy, then further evaluation for hypersomnolence should be considered.

Recall that hypersomnolence, excessive sleepiness, is a new disorder for the *DSM-5*. Addition of this diagnosis conforms to the sleep medicine expert's recommendation for potential comorbid existence.

Adhering to the *DSM-5* dimensional rather than the *DSM-IV-TR* multiaxial classification (Jones, 2012), Jasmine received the following diagnostic formulation:

- 327.23 Moderate obstructive sleep apnea hypopnea (see APA, 2013, pp. 378–383);
- V61.10 Relationship distress with spouse (see APA, 2013, p. 716);

- 296.32 Moderate major depressive disorder, recurrent (the Level 2 — Depression—Adult [PROMIS Emotional Distress—Depression—Short Form] and the Severity Measure for Depression—Adult [Patient Health Questionnaire–9] were administered to determine severity rating (see also Jones, 2012; APA, 2014);
- 327.24 Mild idiopathic sleep-related hypoventilation (see APA, 2013, pp. 387–390);
- 314.01 Mild attention-deficit/hyperactivity disorder, combined presentation, in partial remission (see APA, 2013, pp. 60–61 for discussion on new severity and remission specifier options); and
- 300.02 Mild generalized anxiety disorder (the Severity Measure for Generalized Anxiety Disorder—Adult [APA, 2014] was administered to determine severity rating).

Counselors are reminded that depression, anxiety and cognitive changes often accompany sleep-wake disorders and must be addressed in treatment planning and management (APA, 2013). To assist with targeted treatment interventions for sleep-wake disorders, counselors are encouraged to use Milner and Belicki's (2010) sleep hygiene recommendations.

Neurocognitive Disorders

The *DSM-IV-TR* chapter “Dementia, Delirium, Amnesic, and Other Cognitive Disorders” is renamed to “Neurocognitive Disorders” (NCDs) in the *DSM-5*. Cognitive impairments occur in most mental disorders, including schizophrenia, bipolar disorder, depression, attention-deficit/hyperactivity disorder and autism (APA, 2013). However, the *DSM-5* NCDs work group focused on those disorders for which the cognitive deficit is the primary one and is attributable to known physical or metabolic brain disease—hence the designation *neurocognitive* (Campbell, 2013).

To delineate between normative aging declines and lifelong patterns, the *DSM-5* requires neuropsychological testing as part of the clinical evaluation process (except for delirium). Compared to the *DSM-IV-TR*, the NCDs in the *DSM-5* represent a significant reorganization and reconceptualization (Ganguli, 2011) reflected in two new diagnostic categories: major and mild NCDs (Geda & Nedelska, 2012). Major NCD is characterized by significant cognitive decline, interference with activities of daily living, and symptom manifestation two or more standard deviations from the mean on neurocognitive domains (see Table 1, APA, 2013, pp. 593–595). Specifiers for the major NCD designation include *mild* (difficulties with instrumental activities of daily living, such as housework or managing money), *moderate* (difficulties with basic activities of daily living, such as feeding and dressing), and *severe* (fully dependent).

In contrast to major NCD, mild NCD is characterized in the *DSM-5* as modest cognitive decline, intact activities of daily living, and symptom manifestation one standard deviation from the mean on neurocognitive domains. Mild NCD is a former diagnostic consideration from the *DSM-IV-TR* (2000) Appendix B: Criteria Sets and Axes Provided for Further Study (p. 764). Mild NCD is considered an *up-streaming* diagnostic conceptualization to assist with early diagnostic detection because the neuropathology underlying mild NCD emerges well before the onset of clinical symptoms (APA, 2013).

The *DSM-5* offers two new NCD designations: probable and possible. *Probable* is added to the diagnostic title if there is evidence of a causative disease genetic mutation from either genetic testing, evidence of family history, evidence from laboratory blood testing, or evidence from neuroimaging. *Possible* is used if there is no evidence resulting from the previously mentioned probable objective factors (APA, 2013). Counselors also may use the retained *DSM-IV-TR* descriptive specifier, *without* or *with behavioral disturbance* to indicate the presence of psychotic symptoms, mood disturbance, agitation, apathy or other behavioral symptoms.

The *DSM-5* contains 10 etiological specifiers (formally referred to as subtypes in the *DSM-IV-TR*). The *DSM-5* changed the title of the *DSM-IV-TR* Pick's disease to frontotemporal lobar degeneration and changed the *DSM-IV-TR*'s Creutzfeldt–Jakob disease to Prion disease so as to more objectively communicate the active pathophysiological mechanisms responsible for the neuronal degeneration and resulting cognitive disturbances (APA, 2013). The *DSM-5* added Lewy body disease and multiple etiologies as etiological specifiers and merged the *DSM-IV-TR* dementia due to head trauma and postconcussional disorder (found in Appendix B: Criteria Sets and Axes Provided for Further Study) to become traumatic brain injury (TBI). Counselors will appreciate the table listed on page 626 (APA, 2013) that presents severity ratings for TBI, and will find that Jones, Young, and Leppma's (2010) article complements the *DSM-5* conceptualization of TBI and offers additional assessment and diagnostic assistance.

Clinical Scenario

Jaxson, a male client in his mid-40s who suffered three TBIs, each resulting from independent automobile accidents, presented for counseling. He presented with post-concussion syndromes reflected in physical symptoms (headaches, dizziness, fatigue, noise/light intolerance, insomnia, nausea, physical weakness), cognitive symptoms (memory complaints, poor concentration), and emotional symptoms (depression, anxiety, irritability, increased aggression, mood lability). Textual additions to the *DSM-5* further explained the causal relationship between TBIs and major depressive episodes, facilitating a more accurate clinical formulation. The most salient *DSM-5* (APA, 2013) diagnostic guidelines included the following:

- With moderate and severe TBI, in addition to persistence of neurocognitive deficits, there may be associated neurophysiological, emotional, and behavioral complications. These may include . . . depression, sleep disturbance, fatigue, apathy, inability to resume occupational and social functioning at pre-injury level, and deterioration in interpersonal relationships.
- Moderate and severe TBI have been associated with increased risk of depression. (p. 626)
- Individuals with TBI histories report more depressive symptoms, and these can amplify cognitive complaints and worsen functional outcome. (p. 627)
- There are clear associations, as well as some neuroanatomical correlates, of depression with . . . traumatic brain injury. (p. 181)

Using the *DSM-5*'s Severity Ratings for TBI, three previously administered clinical neuropsychological tests and the *DSM-5*'s Table 1 Neurocognitive Domains, Jaxson received the following dimensional diagnostic formulation per the *DSM-5* (APA, 2013):

- 293.83 Moderate-severe depressive disorder due to TBI, with major depressive-like episode (p. 181; coding rules require that a mental disorder due to another medical condition be listed first; pp. 22–23);
- Moderate-mild disability (87 per self-administered World Health Organization Disability Assessment Schedule [WHODAS] 2.0; pp. 745–748);
- 331.83 Probable mild neurocognitive disorder (NCD) due to TBI (pp. 624–627);
- V62.29 Other problem related to employment (recent change of job, underemployment and psychosocial stressors related to work due to TBI; p. 723); and
- V61.29 Relationship distress with spouse (due to TBI; p. 716).

This approach to clinical case formulation also is demonstrated in the assessment and diagnosis of post-traumatic stress disorder and excoriation (skin-picking) disorder.

Comorbid Diagnostic Formulation

Comorbidity refers to the presence of multiple diagnoses or pathologies within the same individual (Jones, 2012). This final section presents a discussion on the *DSM-5*'s new obsessive-compulsive and related disorder, excoriation (skin-picking) disorder and the revised conceptualization of post-traumatic stress disorder.

Excoriation (Skin-Picking) Disorder

Excoriation, also referred to as dermatillomania (Grant et al., 2012), is characterized by the repetitive and compulsive picking of skin, leading to tissue damage, and is a new diagnosis to the *DSM-5*. This addition reflects the growing prevalence of this psychiatric condition (Grant et al., 2012). Excoriation is characterized by compulsive picking, rubbing, squeezing, lancing or biting of the skin. Not included in this disorder are individual behaviors that involve nail biting, lip biting or cheek biting. If individuals manifest these conditions they are coded as *other specified obsessive-compulsive related disorder* (APA, 2013, p. 263). Cutting, or nonsuicidal self-injury, is not a codable mental disorder in the *DSM-5* (see APA, 2013, pp. 803–806) and is not conceptualized in the symptomology of excoriation. Counselors are encouraged to consider cutting behavior in their clients as manifestations of symptoms related to depressive disorders, bipolar disorders, anxiety disorders, trauma disorders—and most particularly dissociative identity disorder and borderline personality disorder, in which self-injurious behavior is frequent. Individuals engaged in excoriation may target their face, arms, hand, skin irregularities, pimples, calluses or scabs. They may use objects such as tweezers, pins, scissors and fingernails and be triggered by anxiety, boredom, distress or tension (Grant et al., 2012). Some individuals with excoriation display rituals (e.g., biting off, chewing and swallowing skin), permanent skin damage, scarring, lesions, infection or disfigurement. Individuals with excoriation spend several hours per day for months and years picking at their skin, thinking about picking, and resisting urges to pick. Because the skin-picking is so frequent, pain is not routinely reported. Marked functional impairment from excoriation may include work interference, missed school, difficulty managing school tasks and studying, and avoidance of social or entertainment events. Excoriation cannot be due to physiological effects of a substance (e.g., methamphetamine or cocaine), to another medical condition (e.g., scabies), or better explained by symptoms of another disorder (APA, 2013).

Post-Traumatic Stress Disorder

Some important modifications to post-traumatic stress disorder occur in the *DSM-5*. First, the *DSM-IV-TR* language has shifted from “threat to the physical integrity of self or others” (APA, 2000, p. 467) to “sexual violence” (APA, 2013, p. 271). Second, the *DSM-5* removed the *DSM-IV-TR* criterion A2 “subjective fear-based distress” because not all traumatized individuals experience fear, terror or horror when exposed to a trauma stressor. Some traumatized individuals may become anhedonic, dysphoric, aggressive or phobic; experience arousal and reactive-externalizing behaviors; or experience dissociation. Third, a new trauma exposure source is added to the traditional *DSM-IV-TR* trauma sources (i.e., directly experiencing, witnessing, and learning that a traumatic event occurred to a close family member or friend): “experiencing repeated or extreme exposure to aversive details of the traumatic event(s)” (APA, 2013, p. 271). An important note regarding this new exposure source in the *DSM-5* indicates that “criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless exposure is work related” (APA, 2013, p. 271). Examples of work-related electronic media exposure may include an individual who edits graphic news video or pictures, an individual who performs frequent digital-based forensic science investigations of graphic crime scenes, or an individual who views military-oriented electronic images displaying graphic human remains captured from unmanned aerial vehicles. Fourth, the *DSM-5* requires that an individual manifest at least one symptom from each of the following pathological clusters:

- Intrusion symptoms;
- Persistent avoidance of stimuli;
- Negative alterations in cognitions and mood (new to the *DSM-5*); and
- Marked alterations in arousal and reactivity.

Fifth, the *DSM-IV-TR* specifier “delayed onset” is renamed to “delayed expression” in the *DSM-5* so as to communicate whether the full diagnostic criteria are not met until at least 6 months after the trauma-causing event (APA, 2013, p. 272). Sixth, “with dissociative symptoms” (Dalenberg & Carlson, 2012) is a new descriptive specifier that can include either *depersonalization* (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly) or *derealization* (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted; APA, 2013). Seventh, separate diagnostic criterion exist for children ages 6 years and younger. Counselors are encouraged to read van den Heuvel and Seedat (2013) for a detailed review of screening measures and diagnostic instruments for post-traumatic stress disorder in preschool populations.

Clinical Scenario

Mary, a female in her mid-50s, presented with an extensive history of sexual trauma resulting in post-traumatic stress disorder and excoriation. To verify the presence and severity of her trauma and excoriation, Mary was administered the *DSM-5* Level 1 cross-cutting symptom measure. Elevated responses (i.e., *feeling nervous, anxious, frightened, worried, or on edge* and *feeling driven to perform certain behaviors or mental acts over and over again*) triggered administration of the *DSM-5* Level 2 cross-cutting symptom measures (i.e., the Repetitive Thoughts and Behaviors Scale, the National Stressful Events Survey PTSD Short Scale, and the Modified Brief Dissociative Experiences Scale). Adhering to the *DSM-5* dimensional classification, Mary’s diagnostic formulation was conceptualized in the following format:

- 309.81 Moderate post-traumatic stress disorder, with mild depersonalization
- 698.4 Excoriation (skin-picking) disorder.

This diagnostic formulation contains a layered intensity description as both the disorder and the descriptive specifier have a severity rating; hence promoting clinical utility by informing Mary’s treatment plan and assisting with prognostic and outcome factors (APA, 2013). For example, this level of diagnostic precision targeted Mary’s cognitive, affective and behavioral post-traumatic and depersonalization symptoms individually, rather than globally.

Conclusion

The *DSM-5* represents 12 years of culminating work among hundreds of medical and mental health professionals. The manual was revised in a manner so as to stimulate new clinical perspectives, to promote a new generation of research into the biological markers of mental health disorders and to facilitate more reliable diagnoses of the disorders (APA, 2013). This article presented clinical scenarios from actual clients the author worked with in an outpatient counseling private practice. The intent is that counselors feel more comfortable and confident in their use of the *DSM-5* to develop a counseling professional identity that stimulates client growth and development (Erikson & Kress, 2006; King, 2012).

Conflict of Interest and Funding Disclosure

The author reported no conflict of interest or funding contributions for the development of this manuscript.

References

- American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
- American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>
- Baron-Cohen, S., Wheelwright, S., Skinner, R., Martin, J., & Clubley, E. (2001). The autism-spectrum quotient (AQ): Evidence from Asperger Syndrome/high-functioning autism, males and females, scientists and mathematicians. *Journal of Autism and Developmental Disorders, 31*, 5–17. doi:10.1023/A:1005653411471
- Beglinger, L. J., & Smith, T. H. (2001). A review of subtyping in autism and proposed dimensional classification model. *Journal of Autism and Developmental Disorders, 31*, 411–422. doi:10.1023/A:1010616719877
- Bruijnzeel, D., & Tandon, R. (2011). The concept of schizophrenia: From the 1850s to the DSM-5. *Psychiatric Annals, 41*, 289–295. doi:10.3928/00485713-20110425-08
- Campbell, J. J. (2013). What neuropsychiatrists would like to see in DSM-5. *The Journal of Neuropsychiatry and Clinical Neurosciences, 25*, 6–11. doi:10.1176/appi.neuropsych.11040097
- Dalenberg, C., & Carlson, E. B. (2012). Dissociation in posttraumatic stress disorder part II: How theoretical models fit the empirical evidence and recommendations for modifying the diagnostic criteria for PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 551–559. doi: 10.1037/a0027900
- Eriksen, K., & Kress, V. E. (2006). The DSM and professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling, 28*, 202–217.
- Flanagan, E. H., Solomon, L. A., Johnson, A., Ridgway, P., Strauss, J. S., & Davidson, L. (2012). Considering DSM-5: The personal experience of schizophrenia in relation to the DSM-IV-TR criteria. *Psychiatry, 75*, 375–386. doi:101521psyc2012754375
- Ganguli, M., Blacker, D., Blazer, D. G., Grant, I., Jeste, D. V., Paulsen, J. S., . . . Sachdev, P. S. (2011). Classification of neurocognitive disorders in DSM-5: A work in progress. *The American Journal of Geriatric Psychiatry, 19*, 205–210. doi:10.1097/JGP.0b013e3182051ab4
- Geda, Y. E., & Nedelska, Z. (2012). Mild cognitive impairment: A subset of minor neurocognitive disorder? *The American Journal of Geriatric Psychiatry, 20*, 821–826. doi:10.1097/JGP.0b013e31826abc00
- Grant, J. E., Odlaug, B. L., Chamberlain, S. R., Keuthen, N. J., Lochner, C., & Stein, D. J. (2012). Skin picking disorder. *The American Journal of Psychiatry, 169*, 1143–1149.
- Guthrie, W., Swineford, L. B., Wetherby, A. M., & Lord, C. (2013). Comparison of DSM-IV and DSM-5 factor structure models for toddlers with autism spectrum disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 52*, 797–805. doi:10.1016/j.jaac.2013.05.004
- Heckers, S., Barch, D. M., Bustillo, J., Gaebel, W., Gur, R., Malaspina, D., . . . Carpenter, W. (2013). Structure of the psychotic disorders classification in DSM-5. *Schizophrenia Research, 150*, 11–14. doi:10.1016/j.schres.2013.04.039
- Jones, K. D. (2010). The unstructured clinical interview. *Journal of Counseling & Development, 88*, 220–226. doi:10.1002/j.1556-6678.2010.tb00013.x
- Jones, K. D. (2012). Dimensional and cross-cutting assessment in the DSM-5. *Journal of Counseling & Development, 90*, 481–487.
- Jones, K. D., Young, T., & Leppma, M. (2010). Mild traumatic brain injury and posttraumatic stress disorder in returning

- Iraq and Afghanistan war veterans: Implications for assessment and diagnosis. *Journal of Counseling & Development*, 88, 372–376. doi:10.1002/j.1556-6678.2010.tb00036.x
- Kamp-Becker, I., Smidt, J., Ghahreman, M., Heinzl-Gutenbrunner, M., Becker, K., & Remschmidt, H. (2010). Categorical and dimensional structure of autism spectrum disorders: The nosologic validity of Asperger syndrome. *Journal of Autism and Developmental Disorders*, 40, 921–929. doi:10.1007/s10803-010-0939-5
- Kaplan, A. (2013, August 26). Catching up on sleep: From comorbidity to pharmacotherapy. *Psychiatric Times*, 30, 16G. Retrieved from <http://www.psychiatrictimes.com/printpdf/177755>
- Kendler, K. S., Neale, M. C., & Walsh, D. (1995). Evaluating the spectrum concept of schizophrenia in the Roscommon Family Study. *The American Journal of Psychiatry*, 152, 749–754.
- Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hirpis, E., . . . Walters, E. E. (2004). The World Health Organization adult ADHD self-report scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine*, 35, 245–256. doi:10.1017/S0033291704002892
- Ketelaars, C., Horwitz, E., Sytema, S., Bos, J., Wiersma, D., Minderaa, R., & Hartman, C. A. (2008). Brief report: Adults with mild autism spectrum disorders (ASD): Scores on the autism spectrum quotient (AQ) and comorbid psychopathology. *Journal of Autism and Developmental Disorders*, 38, 176–180. doi:10.1007/s10803-007-0358-4
- King, J. H. (2012). *How ethical codes define counselor professional identity* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Order No. 3505737)
- Maenner, M. J., Rice, C. E., Arneson, C. L., Cunniff, C., Schieve, L. A., Carpenter, L. A., . . . Durkin, M. S. (2014). Potential impact of DSM-5 criteria on autism spectrum disorder prevalence estimates. *JAMA Psychiatry*, 71, 292–300. doi:10.1001/jamapsychiatry.2013.3893
- Malaspina, D., Owen, M. J., Heckers, S., Tandon, R., Bustillo, J., Schultz, S., . . . Carpenter, W. (2013). Schizoaffective disorder in the DSM-5. *Schizophrenia Research*, 150, 21–25. doi:10.1016/j.schres.2013.04.026
- Milner, C. E., & Belicki, K. (2010). Assessment and treatment of insomnia in adults: A guide for clinicians. *Journal of Counseling & Development*, 88, 236–244. doi:10.1002/j.1556-6678.2010.tb00015.x
- Rutter, M., & Schopler, E. (1992). Classification of pervasive developmental disorders: Some concepts and practical considerations. *Journal of Autism and Developmental Disorders*, 22, 459–482. doi:10.1007/BF01046322
- Shuster, J. (2012). *Autism spectrum disorder symptoms: An examination of new and existing models* (Doctoral dissertation, York University, Toronto, Canada). Retrieved from <http://www.proquest.com/products-services/dissertations/>
- Tandon, R., Gaebel, W., Barch, D. M., Bustillo, J., Gur, R. E., Heckers, S., . . . Carpenter, W. (2013). Definition and description of schizophrenia in the DSM-5. *Schizophrenia Research*, 150, 3–10. doi:10.1016/j.schres.2013.05.028
- Tanguay, P. E., Robertson, J., & Derrick, A. (1998). A dimensional classification of autism spectrum disorder by social communication domains. *Journal of the American Academy of Child & Adolescent Psychiatry*, 37, 271–277. doi:10.97/00004583-199803000-00011
- van den Heuvel, L. L., & Seedat, S. (2013). Screening and diagnostic considerations in childhood post-traumatic stress disorder. *Neuropsychiatry*, 3, 497–511. doi:10.2217/npj.13.61