Reading, Reflection, Critical Analysis, and Synthesis Paper Assignment

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Abstract

In this review of some chapters from Dailey et al., (2014) and some chapters from Gabbard (2014), we will see a variety of diagnostic criteria and various modalities of working with some of those diagnoses shared. This review will only glimpse at the vast amount of information that can be gleaned from looking critically at the DSM-5 and the various works available in the counseling fields. These valuable works are for us to study to enhance our abilities for those we supervise, students, colleagues, and most importantly, those seeking help and sitting before the mental health professional. We will see some evolution in the long DSM history and adjustments made by adding to or taking away various sections and diagnoses over this evolutionary journey.

Keywords: DSM-5, diagnosis, treatment, changes, counselor

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As we begin our review, it is vital to consider the many people who have dedicated their lives to the vast amounts of research and practice that have transpired. By doing this, these people did so to make a work such as the DSM-5 a reality. This review will help us to have an increased appreciation for these efforts hopefully. In addition, we will cover some information about the progression of the DSM, Depression and Mood Disorders, Obsessive-Compulsive Disorder, Trauma and Stressors Post Traumatic Stress Disorder, Substance-Related and Addictive, Schizophrenia Spectrum and Other Psychotic Disorders. As we take this short journey, some of the changes made to arrive at the current DSM-5 will indeed be interesting to explore.

Dailey et al., Chapter One—Introduction and Overview

The writers assert that all mental health practitioners need to be up to date with the DSM-5 whether DSM diagnosis is a part of their practice. Being up to date will better equip mental health services practitioners to converse with others in the mental health field. Further, it is said counselors need to know the DSM-5 to be able to diagnose correctly. Some in the mental health field do take issue with the idea of trying to make a person fit into a set of standards. The

work being reviewed was written to help better understand the DSM-5 for all mental health providers and especially to assist with the learning requirements of accreditation overseers such as CACREP.

The DSM-5 was a significant update from the previous edition. Work began on this revision in 1999 and was finally released in 2013. Though professional counselors are the second largest group to use the DSM-IV-TR, no professional counselors were on the revision committee. Professional counselors had to depend on the ACA to represent them during the revision process. This manual is focused on highlighting the changes that were made with the DSM-5 from previous issues to help clinicians have a better grasp of these changes. We will see more about changes in the following section.

Reflections from Dailey et al., Chapter Two—Structural, Philosophical, and Major Diagnostic Changes

This chapter begins with the major adjustments and the history of the DSM. The original DSM was published in 1952. The DSM-II was published in 1968. The DSM-III was published in 1980 after a six-year revision process that leaned more on a medical model than had previous versions. The DSM-III-R was published in 1987 and jumped from 106 to 297 diagnoses. The DSM-IV was published in 1994 and did not have many changes but did jump to 365 diagnoses. It is stated that most counselors only use the diagnosis as only one part of treating the whole person.

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The DSM-5 includes both ICD-9-CM and ICD-10-CM codes. The DSM-5 has been arranged differently from previous additions while maintaining close to the same amount of diagnosis found in the DSM-IV-TR addition. The DSM-5 has three key sections. Section one has the revisions made, section two has 20 chapters with like diagnosis grouped, and section three has items for future interest. Within section three is information to assist clinicians in better handling cultural factors that can affect counseling success. The most significant change in the DSM-5 is removing the multi-axial system and the Global Assessment of Functioning. The hope is that the removal of the multi-axial system will help clinicians have a more holistic approach. You will find that the task force for the DSM-5 took a life span approach by grouping similar criteria together. The events that typically affect younger people are towards the front, with items affecting the older population near the end. The update changed some of the language considered to be dated to more modern terms. There continues to be the struggle between environmental or biological and the various stigmatizations associated with each. Depression and Mood Disorders chapter review is upcoming.

Reflections from Dailey et al., (2014) Chapter Three & Reflections from Gabbard (2014) Chapter 12—Depression and Mood Disorders

We will begin by looking at the thoughts from Dailey et al., 2014. This discussion is based on the contents of the DSM-5. There are two primary classifications of mood disorders—1) depressive & 2) bipolar. The chapter on depression has a couple of additions from the previous DSM-IV-TR—1) Disruptive Mood Dysregulation Disorder (DMDD) and 2) Premenstrual

Dysphoric Disorder (PMDD). The writers point out CBT and interpersonal therapy are deemed the two most effective modalities to treat depression at the time of their work. A statistic from the CDC (2010) shared that 10% of adults in the US are affected by depressive disorders. A therapist needs to always check for comorbidities when presented with a client displaying depressive mood disorders. The remainder of the chapter is used to discuss depressive disorders as found in the DSM-5.

First, there is the discussion regarding Disruptive Mood Dysregulation Disorder (DMDD). DMDD was added to accommodate the children who did not align with either the classification of Bipolar Disorder or the classification of Conduct Disorder. The basics are, there must be temper outbursts that are severe in at least one of two settings where it occurs and happen at least three times per week for 12 months in ages 6-18.

Second, we find Major Depressive Disorder Single Episode and Recurrent Episodes (MDD). Symptoms must affect an individual nearly all day, every day, for at least a two-week period, and can be accompanied by feelings as extreme as suicidal ideation. It is best treated by talk therapy that is accompanied by medication. In the latest addition, the bereavement criterion was removed, which was the cause of some controversy. Finally, from a cultural viewpoint, it is interesting that Asians are more apt to display physical issues rather than emotional issues.

Third, Persistent Depressive Disorder (Dysthymia) (PDD) is discussed. These clients must have more days of depression, more days than not, for at least two years. PDD can be

diagnosed alongside MDD. PDD was formerly a mild form of depression but no longer has the mildness factor associated with it under the DSM-5.

Fourth, we come to Premenstrual Dysphoric Disorder (PMDD). This disorder has severe emotional and physical symptoms in the week leading up to a women's period. Symptoms must occur in most menstruation cycles for the year prior to a diagnosis being made.

Fifth, we have Substance/Medication-Induced Depressive Disorder. A diagnosis can be made when; the expected effects of a medication are more severe than expected and continue for more than a month after the medication has been stopped. Clinicians working with these clients need to be aware of the high potential for relapse.

Sixth, they discuss Depressive Disorder Due to Another Medical Condition. This disorder can be directly correlated to the symptomatology of a medical condition. A therapist should confirm the condition's onset at the start of the medical issue, rather than the depressive symptoms being present previously. Therapists should also establish the possible correlation between the onset of depression and any medications being taken for the illness being experienced. Finally, we come to the discussion on Other Specified and Unspecified Depressive Disorders. These classifications were introduced in the DSM-5 to help classify a client who has distress or impairment but does not quite meet the standards for various disorders.

Gabbard (2014) takes an entirely different approach in the way the material is presented.

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The first therapy looked at by the author is Cognitive Therapy (CT). This is one of the best-studied therapeutic processes developed some 40 years ago by Aaron Beck. This model postulates that when you help a person overcome poor thinking, you can help them heal. People with depressed moods are likely to be taking the memories focused on the negative outcomes and then deciding that is an indicator of who they are. The poor outcomes track becomes a self-fulfilling prophecy of defeat. CT can be beneficial in both individual as well as group settings. CT does not view the clinician/client relationship as the most critical issue; however, it is an integral part of counseling. Its value is not to be overlooked. Interestingly, there are potentially few who are actually experts at CT due to the limited amount of training and the idea put forward that most counselors fall back on the less concise methods. It is believed that CT has a farther-reaching positive effect than that of medications.

The second therapy looked at by the author is Interpersonal and Social Rhythm Therapy (IPSRT). IPSRT is effective when used with medications to speed recovery and stop future depressive and manic episodes related to bipolar issues. This method seeks to educate the client regarding bipolar thoroughly and mitigate issues preventing them from following through with the therapeutic process and managing symptomatology that may cause setbacks. The Social Rhythm Therapy aspect is designed to assist the client with healthy routines that can help stabilize mood. The Interpersonal therapeutic process is utilized to assist the client in dealing with the loss of who they may have become or thought they would become. Then it leads to the formulation of goals compatible with the new realities faced through a role transition process.

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Interpersonal role disputes can disrupt relationships due to the sometimes-erratic nature of dealing with bipolar symptoms. Interpersonal deficits develop when bipolar issues are not addressed; those who associate with the client are alienated and, many times, will cease to come around. A study by the University of Pittsburg found that IPSRT could be effective as a stand-alone treatment for those with bipolar II.

The third therapy looked at by the author is Psychodynamic Psychotherapy. Embedded in this theory is the idea that history repeats itself. The client will use prior interactions by which they will interpret current situations. The therapist will attempt to pull some of these attributes to the surface during the sessions. This process, known as transference, will be shared by the therapist when noticed to help the client see how they are using the past in the present, which may or may not be a valid way of interpreting the current situation. The therapist will work to see patterns of perfectionism, defense mechanisms, etc., that may be having a negative outcome for the client. Some studies have shown psychodynamic psychotherapy to be effective but not more effective than other theories.

The fourth therapy looked at by the author is Family-based intervention. This is next up to be discussed. This approach is considered valuable with families with poor communication patterns that are likely to be deemed dysfunctional. Family Focused Therapy (FFT) is designed to help those caring for bipolar clients. This theory sees a correlation between caregivers' high levels of expressed emotions (EE) and poor outcomes. FFT seeks to lessen this stressor by assisting the caregiver with a better understanding that the traits seen as being obstinate etc., are

likely a symptom of having bipolar and not intended defiance. It is believed that this association will assist the caregiver in being less boisterous in their directives towards the client. In addition, FFT hopes to help the caregiver learn to recognize the behaviors that can be controlled and those over which the client has little to no control. A period of psychoeducation is followed up by giving the caregiver a list of potential warning signs and avenues to pursue to prevent relapses. There was also a brief discussion of some group-based modalities that have been seen to increase positive outcomes in families working with a member diagnosed with being bipolar. The discussion on the chapters for obsessive-compulsive disorder is next to be discussed.

Reflections from Dailey et al., (2014) Chapter 6 & Reflections from Gabbard (2014) Chapter 21—Obsessive-Compulsive Disorder (OCD)

Daily et al., (2014) indicate OCD has symptoms of rituals or repetitive activities such as checking the doors to see if they are locked repetitively, skin picking, hand washing excessively due to the idea that one is dirty constantly, etc. OCD was previously called anxiety disorders in the DSM-IV-TR. It seems psychiatrists were on board with the change when not as many counselors were on board due to the similarity in treatment for both anxiety and obsessive disorders. Exposure and Response Prevention (ERP), a type of CBT, is often utilized to help eliminate compulsive behaviors. Counselors need to be cognizant of this information because it seems to affect many adults and adolescents. Some people simply have not been aware that these compulsive actions are not typical for most individuals. A large percentage of the population has characteristics of OCD, so counselors must pay attention to the presence of disruptions in the

client's life due to these events occurrences. OCD is indicated in the DSM-5 to have onset typically for males between age 6-15 and females 20-29. Adolescents should be checked for medical issues that could prompt the onset of compulsive behaviors. OCD symptoms could be a comorbidity with some other disorders (possibly 50%). However, many psychotic disorders can be ruled out if the client can see the behaviors as being outside of accepted norms.

Body Dysphoric Disorder (BDD). This disorder could be an appropriate diagnosis for someone who obsesses about parts of their bodies or all of their body being problematic even when they know, rationally, they are attractive according to social norms and is affecting (disrupting) daily routines. When diagnosing, it is necessary to eliminate any cultural norms that may be promoting the behaviors.

Hoarding. This disorder is associated with collecting items (regardless of actual value) and having high levels of distress for fear you might lose or throw away an item later deemed to be of great importance. The hoarding component is the only similarity to OCD. Hoarding tends to go unnoticed until a person is a bit later in life and has had time to amass a large quantity of items to the level of making various areas of their home unusable. A well-put clarification between a hoarder and a collector is the collector will generally have their items displayed for themselves and others to appreciate where the hoarder simply needs more space to pile stuff with little to no organization. Home safety is an issue to be addressed by a counselor when dealing with extreme hoarding. Other issues (e.g., dramatic events, other diagnoses) that could be causal

should be considered. The level of understanding of the hoarding habits as irregular need to be specified.

Trichotillomania (TTM) (Hair-Pulling Disorder). This disorder is noticed by others and has led to significant hair loss. However, many times this activity is not noticed by the client. TTM was reclassified in the DSM-5 under the obsessive-compulsive heading. Previously, it was located under the impulse control section in the DSM-IV-TR. This change occurred due to TTM delivering a sense of relief rather than satisfaction or pleasure. TTM is typically found in females and has its beginnings around ages 12-13.

Excoriation (Skin-Picking) Disorder. Excoriation occurs when a person has started picking at their skin in an irregular manner compared to cultural norms. It, like TTM, delivers a sense of relief rather than satisfaction or joy. This sense of relief is why it has been included in the obsession-compulsion section of the DSM-5. The counselor treating Excoriation needs to rule out other potential causes and be aware of the potential for skin infections and disfigurement leading to scarring.

Substance/Medication-Induced Obsessive-Compulsive and Related Disorder. This can be diagnosed when the severity of compulsion is more significant than anticipated by the medication and subside after the medication/ substance use has been ceased.

Obsessive-Compulsive and Related Disorder Due to Another Medical Condition. Similar to the previous section because another issue causes its onset, in this case, a medical

condition. Last, we have Other Specified and Unspecified Obsessive-Compulsive and Related Disorders. Other Specified is used when an issue is outside the categorized events (e.g., cheek chewing, nail-biting). Unspecified is used when counselors are uncertain as to the cause of the problems.

Gabbard (2014) starts by sharing the DSM-5 standards to meet the diagnoses requirements for Obsessive-Compulsive Disorder. These include undesirable repetitive behaviors such as skin picking, excessive hand washing, etc., as attempts to relieve the impulse that takes up at least one hour each day. All other potential causes need to be ruled out before diagnosing obsessive-compulsive disorders. The author offers co-therapeutic ideas to exposure therapy such as relaxation, desensitization, fantasy, and imaging techniques that were ineffective. The author then indicates the effectiveness of exposure therapy, explicitly using behavioral therapy (BT) as a guide. When using BT, it is necessary, to begin with, psychoeducation to better prepare the client for what is to come. Education is an effort to alleviate the client's dependency on compulsive behaviors. The use of BT is indicated to have results that occur quickly regarding the behaviors but take a little more time to assist in alleviating the thoughts and feelings. The BT counselor must weigh the balance between an exposure that is substantial enough to affect without scaring the client away from participating in the exposure process. Cognitive therapies have also been beneficial; however, it is not clear if by other means or through the use of exposure therapies as well. Psychodynamic Psychotherapy has not been shown to be effective in treating OCD. Pharmacotherapy has had many medications that have displayed positive results. It seems

apparent that as a singular approach, CBT alone has higher effectual rates than medications alone. There is a slightly higher effective rate when the two are used in combination. A discussion regarding trauma and stressors post-traumatic stress disorder is to follow.

Reflections from Dailey et al., (2014) Chapter 7 & Reflections from Gabbard (2014) Chapter 27—Trauma and Stressors Post Traumatic Stress Disorder (PTSD)

Dailey et al., (2014) state that trauma can be induced by various extreme encounters (e.g., combat, sexual assault) and varies drastically from person to person as to how one responds and processes the events experienced. The introduction of trauma can be displayed in a variety of ways through various individuals. It is interesting to see the evolution that arrived at PTSD. The DSM-I (1952) classified PTSD as gross stress reaction; DSM II (1968) classified PTSD as a situational reaction; The DSM III (1980) coined the term we use today, PTSD. The author now proceeds to go through the various sections found in this section of the DSM-5.

Reactive Attachment Disorder (RAD). This is up first for discussion. RAD must be seen by the age of five and is an effect of sporadic non-affectionate parenting that results in a child not being willing to be comforted by others. Thankfully, it is pointed out that this is not very common as it is a result of extremely deficient parenting. It is essential for the counselor considering a RAD diagnosis to consider the cultural dynamics involved fully. Those who take issue with the RAD diagnosis say it has too great a focus on the child's social behavior rather than being more deliberate about attending to the attachment patterns.

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Disinhibited Social Engagement Disorder (DSED). This is up second for discussion. This classification will display itself in a child who is abnormally accepting of strangers and may even leave with them with little to no hesitation. DSED is like RAD in that poor parenting has led to the lack of appropriate attachment to parental figures. One person is just as good as the next as far as they are concerned. The lack of attachment can be seen in children who have been in orphanages or the foster system with little to no continuity of care. When diagnosing, it is always wise to ensure that the child's behavior is outside the norm for their cultural group.

Post-traumatic stress disorder (PTSD). This is up third for discussion. A person has had to experience severe trauma for a PTSD diagnosis to be considered. PTSD has undergone some changes from the previous DSM-IV-TR. Essentially, it is caused by having experienced a traumatic event and be suffering adverse mental health issues as a direct consequence. PTSD is divided into four clusters in the DSM-5, where it was only three in the DSM-IV-TR. Two new subtypes were added (i.e., preschool subtype and dissociative subtype), and Criterion A.2. was removed due to the belief the standard was not accurate as a predictor. PTSD must have symptoms that are severe and noticeable that cause one to avoid triggers, as well as have cognitive issues. Being in the presence of a traumatic event is not sufficient to diagnose PTSD, but there must be consequences that are present for at least one month. When less than one month, the diagnosis would be acute stress disorder. PTSD can be a debilitating issue that prevents a client from experiencing the joys of life due to reliving the traumatic event or events.

Acute Stress Disorder. This is up fourth for discussion. This classification was introduced in the DSM-IV (1994). The DSM-5 made some adjustments (e.g., the person had to be present for the traumatic event, an event that happened to a close family member). DSM-5 also removed requirements (e.g., helpless, horror). Two critical criteria separate Acute Stress Disorder from PTSD (i.e., last more than three days but less than one month and symptom clusters are unnecessary).

Adjustment Disorders. This is up fifth for discussion and was added in the DSM-III (1980). It covers individuals who experience an adverse life event that cause them to get stuck, indicating they struggle to move past the setback. The event leading to this diagnosis would not be counted as being traumatic. This classification requires the reaction to be exacerbated beyond a typically expected response and then decrease intensity once the stressor is removed. This disruption will be more apt to be seen in adolescents as behavior disruptions vs. adults having more symptoms related to depressive characteristics.

Gabbard (2014) begins the discussion by stating that the amount of literature on PTSD is massive and intends to present the literature in a digestible manner. Many treatment modalities were examined across 26 studies that nearly all had positive outcomes, but CBT rises to the top as the go-to approach for treating PTSD. CBT takes strides to address the issues causing the dysregulation symptoms and looks at the faulty thinking that may be occurring around these events. Prolonged exposure (PE), cognitive processing therapy (CPT), and eye movement desensitization and reprocessing (EMDR) are what the author refers to as forms of CBT proven

as effective in the treatment of PTSD. The author provides a table to help delineate the changes found from the DSM-IV-TR to the DSM-5. One of the most noticeable is that PTSD is now in a category called trauma and related disorders, where it had been previously in the anxiety disorder section.

Exposure therapy (ET) helps the client face the trauma and the emotions surrounding the event and then begin to place the memory in a healthy context that can be managed. ET is the go-to for the treatment of PTSD successfully. Next, the author begins a discussion about pharmacotherapy. As effective as ET, CBT, and other therapies have proven to be, some will either not respond well to talk therapy or do not have access to it. Therefore, the need for medications is still a necessary and somewhat effective treatment for PTSD. A combination of medications and talk therapy is included in the section on future efforts to treat PTSD. Therapy treatment for PTSD is generally in person; however, there is evidence for the effectiveness of Telehealth therapy to treat PTSD. The chapters up for review following are those covering substance and addictive behaviors.

Reflections from Dailey et al., (2014) Chapter 9 & Reflections from Gabbard (2014) Chapter 56—Substance-Related and Addictive

Implications from Dailey et al., (2014) indicate a pandemic of sorts is occurring in the US with the number of people using and abusing various drugs. Addiction is not biased to who is affected. Because of the overwhelming rate of use, all counselors need to have some knowledge of how to help a person dealing with addiction. Every counselor will likely be faced with a

person struggling with addiction someday. The terms abuse and dependence were removed in the DSM-5. Now there are mild, moderate, and severe ratings that can be applied. Another noticeable change was moving gambling to the chapter on substance addiction. This move was due to the similarities found in how the brain reacts to each. Each substance has a variety of specifiers and classifiers to indicate the level of use, using or withdrawing, and what substance/activity is being used. There can be multiple substance use specifiers given in the same diagnosis. Generally, it is expected that comorbidity of substances will be present. Using the mild, moderate, and severe levels can help assign treatments suited to the client's actual situation.

Gabbard (2014) begins the chapter with a discussion of psychotherapy and counseling. I have always used these terms interchangeably. The author distinguishes the psychotherapist as being trained on the master or doctoral level and makes the counselor sound like a general worker at a mental facility. However, in the very next paragraph, it is said that the two have basically merged into the same thing. In the section discussing 12 step programs, it is shared that the philosophy is to address the whole person (i.e., spiritual, physical, mental). The combination of simply checking (e.g., urine testing) is valuable to help clients to stay on track during the early phases of treatment. It would seem there is no die-hard science as to how often to have counseling sessions with recovering addicts. One indication suggested the shorter length with more frequent sessions may be more beneficial in treating addiction behaviors. Dropout rates seem to be higher with certain addictions.

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Further research was recommended to address potential methods to assist these groups with ways to last longer in therapy to help them improve over time. In the section on therapeutic alliance and opioid use, the author seems to make a case for specific modalities and then demonstrate those modalities to be ineffective (confusing). In the cocaine use section, the results of studies indicate various effects, with no one answer as the overarching way to treat cocaine addiction. However, the section does conclude with multiple methodologies that all showed to reduce the level of cocaine use. A similar outcome was touted for alcohol addiction. In the cannabis section, there was a finding shared regarding one session of modality A verse 16 weeks of modality B. The finding found that the 16-week modality had better results (not to disparage the work, but that indeed seems like a flawed, or at best, a skewed method of comparison). The section did conclude with most modalities looked at produced positive results.

I am finding it challenging to appreciate parts of what I am reading. For example, in the comorbid psychiatric disorders section, the author quotes a person stating personality disorders are common with those addicted to substances. I would argue that substance addiction is common with those who deal with personality disorders (the whole chicken and egg, which came first discussion). The remainder of the section, on comorbid psychiatric disorders, quotes a study of 105 patients with or without psychiatric disorders (perplexing). The chapter concludes by reminding us that no one method became apparent as the go-to for addiction treatment. Though unclear what the author intended meaning is for separating counseling and psychotherapy terms as being different, their finding indicates that each is about equally effective with the treatment

of addictions. An interesting review of the chapters on schizophrenia and psychotic disorders is to follow.

Reflections from Dailey et al., (2014) Chapter 13 & Reflections from Gabbard (2014) Chapter 68—Schizophrenia Spectrum and Other Psychotic Disorders

Dailey et al., (2014) begin this chapter by sharing that schizophrenia has a variety of symptoms (e.g., hallucinations, delusions). Delusions are beliefs that do not align with reality, whereas hallucinations are sensory distortions they experience as real, even though not shared by anyone else. The DSM-5 added the element that depressive and manic issues be present more times than not for a diagnosis of schizoaffective. An interesting thought, yet potential overreach, is found in section III of the DSM-5. They propose the attenuated psychosis syndrome, a tool that attempts to pick out those at higher risk of development of Schizophrenia and related issues. It was met with controversy over fears of labeling individuals who will likely never develop an actual psychotic issue. Any client who presents with symptoms congruent to schizophrenia needs to be referred to their medical doctor to rule out any potential medical causation. Individuals on the Schizophrenia chart have almost certainly experienced trauma, have depressive symptoms, as well as comorbid medical and mental conditions. It can be an essential part of care for the clinicians involved to have a positive relationship with their client to help facilitate medication education and compliance, treatment, and simply allow the client to adjust to a new reality. The author now shares the different diagnoses found in this section of the DSM-5 in an abbreviated manner.

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First, Delusional Disorder. This must be occurring for at least one month with at least one delusion (not sure if this delusion must persist for the month). Other diagnoses can be ruled out and have no odd characteristics when not experiencing a delusion. These delusions can be challenging to catch because they are limited, and the events may be entirely plausible. However, there are specifiers to help make clear the level of the events experienced.

Second, Brief Psychotic Disorder. This must be experienced from one day to one month with sudden onset of symptoms. It is essential to have a client get checked by their medical provider because the onset of this is generally a side effect of another issue. There are specifiers for brief psychotic disorders.

Third, Schizophreniform Disorder. This must occur between 1-6 months and is generally a stepping-stone towards a schizophrenia diagnosis. Two out of three people faced with this diagnosis end up with a full-blown diagnosis of schizophrenia. Some research is being done regarding combinations of treatments to help at the onset of symptoms.

Fourth, Schizophrenia. This is a crippling diagnosis to receive. It is crucial to work with the client to help life be as stable and productive as possible. It is appropriate to help the family members be equipped to be a support system to assist the client with their quality of life. Multiple specifiers should be used when diagnosing schizophrenia.

Fifth, Schizoaffective disorder which is diagnosed. This occurs when schizophrenia episodes occur alongside either depressive or manic episodes. This disorder is not considered

concrete and has been suggested it would be better suited as comorbidities. However, with this diagnosis, the treatment group may have to treat the most apparent symptom at the current time.

Sixth, Substance/Medication-Induced Psychotic Disorder. This is diagnosed when it is probable the onset was due to a substance being ingested. Treatment will likely begin with the care of a medical doctor.

Seventh, Psychotic Disorder Due to Another Medical Condition. This is diagnosed when it is probable the onset was due to a medical diagnosis. Treatment will likely begin with the care of a medical doctor.

Gabbard (2014) begins by sharing the various disorders associated with the schizophrenia scale of diagnoses. The idea that many who suffer from schizophrenia type disorders often have a deficit in reading body language or understanding what is being experienced by others without it being pointed out can be lost. In this chapter, three main categories of schizophrenia spectrum are discussed—paranoid PD (PPD), schizotypal PD (STPD), schizoid PD (SZPD).

First, Paranoid Personality Disorder (PPD) is discussed. The issues of distrust, misreading, etc., associated with PPD can be related to psychotic disorders but do not occur exclusively with them. The actions of a paranoid person, many times, become a self-fulfilling prophecy. The person with PPD will be convinced the world is against them and then find it to be proven when those very persons will no longer tolerate the odd behaviors.

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In the section regarding psychotherapy, the idea is shared that the person dealing with PPD will rarely decide unilaterally to seek help. It depends on how encompassing the paranoia is in an individual, as to how difficult getting them to treatment may be for family or friends. They may have to be very insistent. The clinician must take extra intentionality to avoid confrontations that would likely drive the client out of therapy and never return. The clinician must make efforts to delineate between the fabrications of the mind and the events that are actually occurring.

The client with PPD will find it difficult to navigate daily life due to misinterpreting signals sent through conversation. For example, it is common to understand a friendly gesture as a threat. These misreads can lead to terrible situations of feeling belittled, leading to isolation—a vicious cycle of potential defeat. Possibly due to trauma experienced or simply through the depredation that has internally taken place, some dealing with PPD will think very little of themselves. The therapist will need to look for opportunities to assist the client with the improvement of this deficiency. Sometimes this may be accomplished by a change of venue or simply giving them permission to do certain things they may believe themselves unworthy of the privilege to participate. One of the tools used is CBT to help challenge some of the notions assumed by the client with PPD. However, it must be done in a non-confrontational manner. In a brief discussion regarding group therapy, it was deemed not typically a great idea due to the high potential for misdirected reactions both given and taken by the participants. In another confusing section, the discussion pointed out that medications are generally not helpful and then gives an example of how useful medication can be to relieve distress.

Second, Schizotypal Personality Disorder (STPD) is discussed. With this disorder, the client is likely to read events in life as directly affecting themselves even when one has nothing to do with the other. They may believe themselves to have powers (e.g., magical) or find themselves never being comfortable with acquaintances, even after some time has passed, which may be a causation of the lack of friends, which is also an indicator. There may also be some delusional aspects or eccentric behaviors that appear odd to others. There are not many studies covering STPD due to the difficulty of measuring the changes that occur. Drug abuse can be a precursor of STPD, with cannabis being specifically mentioned. Three modalities were suggested as therapies to be utilized: Dynamic, Cognitive Behavioral, and Supportive. Clinicians are left having to rely on one another when dealing with STPD issues due to the lack of research.

Third, Schizoid Personality Disorder (SZPD) is discussed. The people dealing with SZPD will have little to no interest in friends or social gatherings and will generally appear to be downcast. This person will appear cold and not seem to take pleasure in many activities culturally deemed normal to enjoy (e.g., sex, compliments, general activities). Group therapy can typically be ruled out. Medications are not known to be beneficial, so the primary method of treatment is supportive psychotherapy. Next, we look ahead at personality disorders.

Reflections from Dailey et al., Chapter 16—Looking Ahead: Personality Disorders

In this chapter, the discussion leads to the topic of a proposed method of diagnosing personality disorders. This inclusion seems to be an attempt to taint the waters with their ideas, so they will appear to be the norm once implemented in a future addition. The current criterion is

anticipated to change, and they are simply preparing the users. The personality disorders in section 3 are grouped by what, in this addition, is called clusters, which is odd because the writers of this chapter indicate there is no research to support the cluster model. Again, it seems like the DSM group intends to put this information out and is attempting to acclimate people to the style so there will not be any or little dispute when it is implemented. It seems apparent that the committee for the DSM-5 saw the shortfalls of the models for personality disorders put forth in section three, which explains why there was little change from the DSM-IV-TR to the DSM 5.

The chapter has characteristics that tend to make many of the claims made in the DSM-5 seem overly fluid in their interpretation. The author gives an example of how some cultures are more apt to work hard, which could lead to a diagnosis of obsessive personality disorder. If criterion indicates a trait or traits as being indicative of a disorder, why would it make it acceptable, simply because a particular cultural group made these actions their norm? Something seems to be a bit off about this chapter. The end of one paragraph indicates that professional counselors will not typically make a diagnosis, then the next paragraph issues caution for counselors making diagnoses. The bulk of the chapter discusses in some detail various personality disorders. It continues to sound strange that the DSM-5 task force included the models in section three due to what the author of this chapter says has a "lack of clinical utility and a lack of empirical evidence." These seem like criteria for non-inclusion rather than evidence to support them being included for research potential.

Additionally, there is more confusion with statements like "they do not change" but have "variability." This chapter offers some details about the personality disorders included in the DSM-5. Overall, the chapter appears to have many deficits. The final one we will discuss involves the sample cases at the end. Why would the fact that the man is heterosexual be a factor in what is being discussed? It is not necessary to bring a person's sexual choices into every discussion. The following chapter covered is regarding implications for counselors.

Reflections from Dailey et al., Chapter 17—Practice Implications for Counselors

This chapter will help to shed some light on using various items found in the DSM-5.

Specified and Unspecified Diagnoses—This addition in the DSM-5 allows a clinician to add an additional diagnosis when the specifiers have not been met.

Coding Procedures. The team for the DSM-5 recognized that it would take some time for 3rd party payers to transition from the previous axil system to the new coding system. It was mandated that these companies have in place and accept the new codes by October 2014. The new system has codes that can be input to specify a diagnosis. There is some concern when a counselor puts a diagnosis of a medical nature seeing as they are not qualified to make a medical diagnosis. It is indicated that client self-reporting should be noted separately. There is also the notation to avoid the temptation to up-code or down-code but to only use the appropriate code for what the client presents.

New Assessment Tools. The DSM-5 was intended to have multiple assessments for each diagnosis. Even though the revision team decided these measures were not validated, they have made some of them available on the DSM website. These were intended to be a way to help clinicians be more confident in their diagnoses. Some of the assessments are available on the website. However, it was questioned whether these assessments are suited for everyday use by the clinician.

The Cultural Formulation Interview (CFI). This tool was to assist the clinician in making appropriate adjustments that may be needed when meeting with clients who may have different cultural dynamics than the therapist. Some aspects are potentially problematic (i.e., being too structured). However, the team for the DSM-5 believed simply having the questions as a guide could help facilitate the needed adjustments regarding cultural differences. What are the future implications for all levels of the counseling world? We will look in the next section to get a glimpse.

Implications for Counseling, Supervision, Counselor Education, Research and Scholarship, and Leadership and Advocacy in the Field of Professional Counseling

What we can glean from the topics just reviewed is that the counseling world is ever-growing. I say growing rather than changing because the situations being dealt with are not necessarily changing but not having arrived at the pentacle of knowledge. We need more research and data collection. We have come so far in the counseling field but are so far behind

where we would like to be in the field. Thus, we need more information to understand better the various aspects of the many behavioral issues, modalities to treat with, and the impact of the general demeanor of the clinicians involved with treatment—Hence the term growing. We need all sectors of the counseling world to be present and active for the field to continue forward progress. We often forget about the value of those doing research if we are not attempting to stay current. Just imagine where the counseling field would be if the many studies done over the years had not been. Imagine if the original DSM had been the end-all-be-all of the counseling world. It is also essential that those doing supervision and counselor education be informed (up to date) on the current modalities so the counselor sitting before the client can be pouring out the best help possible.

Conclusion

The diagnoses and treatments just reviewed give us some clarification of the changes that have been made throughout the progression of the DSM journey. The DSM is a living document of sorts the should continue to change with research findings but will also likely continue to change with the whims of the political agendas of those who have the final ability to include items in future editions. Continued research and learning through the observations had by practitioners of therapies with their clients should continue to shape the world of counseling.

Reading, Reflection, Critical and Synthesis

Reference

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