DSM-5™ IN ACTION

REVISED EDITION

SOPHIA F. DZIEGIELEWSKI

WILEY

DSM-5™ in Action

SOPHIA F. DZIEGIELEWSKI

WILEY

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A Tribute to Dr. Cheryl Green

I have come to believe that intelligence consists of the knowledge that one acquires over a lifetime. Wisdom, however, is far greater. Wisdom requires having intelligence, but realizing it means nothing if it is not shared. In wisdom, there is a natural sense of giving where there is no fear of loss. It means realizing that the knowledge is measured purely by what we can teach and share with others.

For Dr. Cheryl Green, her intelligence made her a social work scholar. It was her wisdom, however, that touched my soul and made her one of my colleagues and dearest friends. Her sense of humor and "Cherylisms" made the time fly by. Cheryl passed on before the formulation of this book. Through her teaching and writing, the hearts of so many social workers like me will never be the same. Although not a day goes by that I do not miss my dearest friend, I remain comforted by the time we shared together.

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Preface

The pages that follow will introduce the reader to the diagnostic assessment, with its obvious strengths as well as its limitations. Although the concept of diagnosis and assessment is rich in tradition, the connection between diagnostic procedures and behavioral-based outcomes calls for a practice strategy that recognizes the importance of the relationship between the problems and concerns of the person and his or her environment. Continually assessing and reassessing how to best address context changes related to emotional, physical, and situational factors regarding client well-being is paramount.

This book stresses a multidisciplinary and interdisciplinary focus that invites all medically and nonmedically trained professionals, social workers, and other mental health practitioners to join in a collaborative team-based approach. By working together, teams best serve clients' needs by providing a comprehensive diagnostic assessment that ensures high-quality care.

This book utilizes the diagnostic nomenclature outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) and goes beyond the *DSM* to clearly suggest treatment planning and application. The diagnostic assessment is embedded in the use of supporting texts, also referred to as the bibles of mental health, such as the *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (*DSM-5*; American Psychiatric Association, 2013) and the *International Classification of Diseases,* ninth and 10th editions (*ICD-9-CM* and *ICD-10-CM*; World Health Organization, 1993, 2008). These books have been the standards for mental health practice for decades. Therefore, it should come as no surprise to mental health professionals that the new edition, the *DSM-5,* which crosswalks insurance billing with the *ICD-10,* with its latest mandatory requirement for usage in October 2015, will bring what some consider earth-shaking changes.

Familiarity with these books is important for completing the diagnostic assessment, and all mental health professionals need to understand this information and how to incorporate it to provide a competent, efficient, and effective practice strategy. To assist in this process, this book outlines the basic diagnostic information related to the *DSM-5* and suggests treatment strategy.

Similar to previous editions, this edition of this text continues to serve as a handbook that extends beyond just learning the criteria for a diagnosis. After providing an overview of the basics, the text extends to treatment strategy with the creation of treatment plans, including suggestions for individualizing the best therapeutic services available. In using the *DSM,* concerns remain about misdiagnosis, overdiagnosis, and labeling clients—all practices that can have severe repercussions personally, medically, socially, and occupationally—and the need for informed, ethical practice has never been more important. The early stages of transition to the *DSM-5* will require balancing the knowledge of both books, the *DSM-IV-TR* and *DSM-5.* Mental health practitioners believe strongly in allowing ethical principles, environmental factors, and

a respect for cultural diversity to guide all practice decisions. From this perspective, the diagnostic assessment described in this book embodies concepts such as individual dignity, worth, respect, and nonjudgmental attitudes.

For social workers and other mental health counselors (often referred to as practitioners), recognizing these values is the cornerstone from which all treatment planning and intervention is built. Many times these concepts remain subjective and require professional acknowledgment, interpretation, and application extending beyond the formal diagnostic criteria and requiring interpretation and application strategies that lead to efficient and effective practice strategy. What is most important to remember is that the *DSM,* regardless of the version, does not suggest treatment. My hope is that this book will help to further the crosswalk as the *DSM* works with the *ICD* in terms of billing and that this book will outline a comprehensive diagnostic assessment leading directly to the treatment and treatment planning essential for the implementation of practice strategy.

OVERVIEW

To start this endeavor, the four chapters of Section I introduce the reader to the major diagnostic assessment schemes utilized in the profession and through this diagnostic lens outline both support and resistance issues. In these introductory chapters, the basics of diagnosis and assessment are exemplified in relation to how these terms are applied in current health and mental health practice. The learning process begins with an understanding of how terms such as *diagnosis* and *assessment* are combined in relation to current health and mental health practice. A historical perspective provides the background of the *DSM,* comparing the similarities and differences from previous editions and the rationale for the latest version, the *DSM-5.* Further, this section summarizes the current expectations and controversies surrounding the *DSM-5.* Taken into account in *DSM-5* is the importance of including supporting information, such as use of the dimensional assessment, crosscutting of symptoms, and use of the Cultural Formulation Interview (CFI). It ends with an overview of how the "In Action" connection is made, linking the diagnostic impression to treatment planning and practice strategy. Case examples show the application of the theoretical concepts and demonstrate how these principles relate to practice strategy.

Section II provides comprehensive diagnostic information for each selected category of disorder, identifying commonly seen psychiatric mental health conditions. Each chapter contains *Quick References* designed to highlight the most important diagnostic criteria clearly and concisely. The case examples show how the criteria can manifest. For each category of disorders outlined in the application chapters, at least one disorder highlights the "In Action" focus of the book. The case example provides a comprehensive diagnostic assessment and treatment plan that reflects the related practice strategy.

Additional treatment plans were one of the most popular features of previous editions of this book, and they have been expanded. Treatment planning is essential to practice strategy, and regardless of whether the *DSM* or the *ICD* is used for diagnostic purposes, the treatment plans and intervention strategy will remain similar. Therefore, the appendix covers selected disorders not addressed in the individual chapters, and also added are selected quick references that clearly outline the criteria. Each treatment plan explains the signs and symptoms that should be recorded, what the short- and long-range goals for the client are, and what needs to be done by the client, the practitioner, and the family.

Uniqueness of This Book

What remains unique about this book is that it challenges the practitioner to synthesize information into a complete diagnostic assessment that bridges the diagnostic assessment to current treatment planning and practice strategy. Each chapter, along with the quick references, is designed to give health and mental health practitioners a sense of hands-on learning and participation. This book is not meant to include all aspects of a mental disorder and its subsequent treatment. Rather, it provides a framework for approaching the disorder, with suggestions for the treatment that will follow.

Therefore, this book provides a reader-friendly comprehensive reference to the most commonly diagnosed mental disorders, as well as specific applications designed to show how to apply the diagnostic framework toward current practice strategy. Each disorder was carefully selected, based on what is most often seen in the field and taught in the graduate-level classroom. In addition, based on the prevalence of these diagnoses, the disorders covered in this book are often included on social work and other mental health–related licensing exams.

On a personal note, I believe creating a reader-friendly, practice-based handbook of this nature is never easy—nor should it be. Creating the best diagnostic assessment takes a lot of hard work, and all practice wisdom must be grounded in individualized, evidence-based practice strategy. Therefore, the actual drafting of chapters of this edition from the first proposal to the end product covered a span of well over 4 years, with numerous rewrites and edits. This book represents more than 25 years of my professional practice and teaching experience. In addition, I have worked with all the contributing authors of the application chapters, all are fellow practitioners in the area, and together we have spent countless hours deciding on how best to transcribe practice experience into the written word. All the contributors to this text are passionate about our profession and agree that much needs to be learned from the clients served. We all believe strongly that diagnostic skill will always fall short if it is not linked to practice strategy.

Case examples are used throughout this book to help the reader see the interface between what is written in the text and how it applies to practice. Many of the struggles that other professionals have noted are highlighted, and the case examples present information in a practical and informative way that is sensitive to the client's best interests while taking into account the reality of the practice environment. Thus, the contributors invite the reader to begin this adventure in learning and to realize that diagnostic assessment needs to be more than "the Blind Man and the Elephant."

There will always be a subjective nature to diagnosis and assessment, just as there is a subjective nature to individuals and the best-employed intervention strategy. The person-in-situation stance provides the strongest link to the successful diagnostic assessment, which can often be overlooked. This edition, like the ones before it, is intended to take the practitioner beyond the traditional diagnostic assessment and ignite a creative fire for practice strategy and implementation, similar to what it has done for those in our profession. The importance of the person-in-environment and of including supportive characteristics related to individuals, families, and the related support system will always stand in the forefront of the successful application of treatment strategy. Welcome to this latest edition, and with each client served, I hope you never forget the importance of the three Rs: Recognition, Respect, and Responsibility.

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I would like to thank my clients for teaching me the importance of going beyond what is expected and recognizing the uniqueness of each individual I have had the privilege of serving. Seeing firsthand the stigma and subsequent danger of placing a label on a client has left me sensitive to ensuring that the diagnostic assessment is not done haphazardly and always takes into account the person-in-situation or person-in-environment perspective. This means that each encounter must first recognize the uniqueness of the individual, show respect for the client and his or her situation, and take responsibility for providing the most comprehensive diagnostic assessment and subsequent treatment available.

Furthermore, the final product is only as good as those who work diligently behind the scenes on the editing and production of this book. First, I would like to thank Barbara Maisevich, MSW, for her second set of eyes and technical support in completing this manuscript. I would also like to thank Rachel Livsey, Senior Editor, Social Work and Counseling, and Kim Nir, editor "extraordinaire" at John Wiley & Sons. I would like to thank both of these individuals for their openness to new ideas, high energy level, drive, ambition, and perseverance making them both wise teachers, mentors, colleagues, and now my friends.

Last, I want to thank my family members, friends, and colleagues who understood and supported me when I said I could not participate because I had to work on this book. Special thanks to my husband who for 35 years always listens and understands the stress another deadline places on our time together. I am a firm believer that the more we share with others, the greater the gifts we receive in return. Therefore, it comes as no surprise that I am blessed with knowing and working with so many caring and supportive family members, friends, and colleagues. With that level of encouragement and support, all things really are possible.

Sophia F. Dziegielewski

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Section I

UTILIZING THE *DSM-5*: ASSESSMENT, PLANNING, AND PRACTICE STRATEGY

CHAPTER 1

Getting Started

INTRODUCTION

This chapter introduces the concepts and current application principles relating psychopathology to clinical mental health practice. This application is supported through the use and explication of diagnosis-assessment skills found in today's behavioral-based biopsychosocial field of practice. The major diagnostic assessment schemes utilized in the profession, along with support and resistance issues, are introduced. Diagnosis and assessment are applied to current mental health practice. A historical perspective is explored, and the type of diagnostic assessment most utilized today is outlined. Practice strategy is highlighted, and considerations for future exploration and refinement are noted.

BEGINNING THE PROCESS

The concept of formulating and completing a diagnostic assessment is embedded in the history and practice of the clinical mental health counseling strategy. Sadler (2002) defined the traditional purpose of the psychiatric diagnosis as providing efficient and effective communication among professionals, facilitating empirical research in psychopathology, and assisting in the formulation of the appropriate treatment strategy for the client to be served. The importance of the diagnostic assessment is supported by estimates related to the prevalence of mental disorders in our population and the effects it can have on human function and productivity. It is estimated that each year, a quarter of Americans are suffering from a clinical mental disorder. Of this group, nearly half are diagnosed with two or more disorders (Kessler, Chiu, Demler, & Walters, 2005). Paula Caplan (2012), a clinical and research psychologist, wrote in the *Washington Post* that about half of all Americans can expect to get a psychiatric diagnosis in their lifetime. Although on the surface these numbers may seem alarming, some researchers question whether these incidences of mental disorders are simply a product of our times and related primarily to the taxonomy used to define a mental disorder (Ahn & Kim, 2008). In practice, this rich tradition related to making the diagnostic impression has been clearly emphasized by compelling demands to address practice reimbursement (Braun & Cox, 2005; Davis & Meier, 2001; Kielbasa, Pomerantz, Krohn, & Sullivan, 2004; Sadler, 2002). For example, whether a client has health insurance can be a factor in whether he or she gets a mental health diagnosis and the supporting treatment received (Pomerantz & Segrist, 2006). Also, use of the *DSM* and creating a psychiatric diagnosis continue to go basically unregulated and open to professional interpretation (Caplan, 2012).

To facilitate making the diagnostic impression, numerous types of diagnosis and assessment measurements are currently available—many of which are structured into unique categories and classification schemes. All mental health professionals need to be familiar with the texts often

referred to by those in the field as the bibles of mental health treatment. These resources, representing the most prominent methods of diagnosis and assessment, are the ones that are most commonly used and accepted in health service delivery. Although it is beyond our scope to describe the details and applications of all of these different tools and the criteria for each of the mental disorders described, familiarity with those most commonly utilized is essential. Furthermore, this book takes the practicing professional beyond assessment by presenting the most current methods used to support the diagnostic assessment and introducing interventions based on current practice wisdom, focusing on the latest evidence-based interventions utilized in the field.

MAKING THE DIAGNOSTIC ASSESSMENT: TOOLS THAT FACILITATE THE ASSESSMENT PROCESS

Few professionals would debate that the most commonly used and accepted sources of diagnostic criteria are the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) and the *International Classification of Diseases, Tenth Edition* (*ICD-10*) or the *International Classification of Diseases* (*ICD-11*). Across the continents, especially in the United States, these books are considered reflective of the official nomenclature designed to better understand mental health phenomena and are used in most health-related facilities. The *DSM-5* (American Psychiatric Association [APA], 2013) is the most current version of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (APA), which replaced the *DSM-IV-TR* (APA, 2000).

Today, the *DSM* has similarities to the criteria listed in the *ICD* in terms of diagnostic codes and the billing categories; however, this was not always the case. In the late 1980s, it was not unusual to hear complaints from other clinicians related to having to use the *ICD* for clarity in billing while referring to the *DSM* for clarity of the diagnostic criteria. Psychiatrists, psychologists, social workers, and mental health technicians often complained about the lack of clarity and uniformity of criteria in both of these texts. Therefore, it comes as no surprise that later versions of these texts responded to the professional dissatisfaction over the disparity between the two texts, as well as the clarity of the diagnostic criteria. To facilitate practice utility, the *DSM-5,* like its previous versions, serves as a crosswalk between the two books, utilizing the criteria from the *DSM* to facilitate forming the diagnostic impression and utilizing the *ICD* for billing. Balancing the use of these two books is essential in formulating a comprehensive diagnostic assessment. Use of these two books, clearly relating them to each other with their closely related criteria and descriptive classification systems, crosses all theoretical orientations.

Historically, most practitioners are knowledgeable about both books, but the *DSM* is often the focus and has gained the greatest popularity in the United States, making it the resource tool most often used by psychiatrists, psychologists, psychiatric nurses, social workers, and other mental health professionals.

ROLE OF SOCIAL WORKERS AND OTHER MENTAL HEALTH PROFESSIONALS

The publisher of the *DSM* is the American Psychiatric Association, a professional organization in the field of psychiatry. Nevertheless, individuals who are not psychiatrists buy and use the majority of copies. Early in the introductory pages of the book, the authors remind the reader that the book is designed to be utilized by professionals in all areas of mental health,

including psychiatrists, physicians, psychiatric nurses, psychologists, social workers, and other mental health professionals (APA, 2013). Since there is a need for a system that accurately identifies and classifies biopsychosocial symptoms and for using this classification scheme as a basis for assessing mental health problems, it is no surprise that this book continues to maintain its popularity.

Of the documented 650,500 jobs held by social workers in the United States, more than 57% are in the area of health, mental health, substance abuse, medical social work, and public health, where many are directly involved in the diagnostic process (Bureau of Labor Statistics, U.S. Department of Labor, 2012). When compared with psychiatrists, psychologists, and psychiatric nurses, social workers are the largest group of mental health providers with a significant effect on diagnostic impressions related to the current and continued mental health of all clients served.

Mental health practitioners (also referred to as clinicians), such as social workers, are active in clinical assessment and intervention planning. Back as far as 1988, Kutchins and Kirk reported that when they surveyed clinical social workers in the area of mental health, the *DSM* was the publication used most often. Furthermore, since all states in the United States and the District of Columbia require some form of licensing, certification, or registration to engage in professional practice as a social worker (Bureau of Labor Statistics, U.S. Department of Labor, 2012), a thorough knowledge of the *DSM* is considered essential for competent clinical practice.

Because all professionals working in the area of mental health need to be capable of service reimbursement and to be proficient in diagnostic assessment and treatment planning, it is not surprising that the majority of mental health professionals support the use of this manual (Dziegielewski, 2013; Dziegielewski, Johnson, & Webb, 2002). Nevertheless, historically some professionals such as Carlton (1989), a social worker, questioned this choice. Carlton believed that all health and mental health intervention needed to go beyond the traditional bounds of simply diagnosing a client's mental health condition. From this perspective, social, situational, and environmental factors were considered key ingredients for addressing client problems. To remain consistent with the person-in-situation stance, utilizing the *DSM* as the path of least resistance might lead to a largely successful fight—yet would it win the war? Carlton, along with other professionals of his time, feared that the battle was being fought on the wrong battlefield and advocated a more comprehensive system of reimbursement that took into account environmental aspects. Questions raised include: How is the *DSM* used? Is it actually used to direct clinical interventions in clinical practice? Or is the focus and use of the manual primarily limited to ensuring third-party reimbursements, qualifying for agency service, or avoiding a diagnostic label? Psychiatrists and psychologists also questioned how the *DSM* serves clients in terms of clinical utility (First & Westen, 2007; Hoffer, 2008). Concerns evolved that clients were not always given diagnoses based on diagnostic criteria and that the diagnostic labels assigned were connected to unrelated factors, such as individual clinical judgment or simply to secure reimbursement. These concerns related directly to professional misconduct caused ethical and legal dilemmas that affected billable and nonbillable conditions that had intended and unintended consequences for clients. To complicate the situation further, to provide the most relevant and affordable services, many health care insurers require a diagnostic code. This can be problematic, from a social work perspective, when the assistance needed to improve mental health functioning may rest primarily in providing family support or working to increase support systems within the environment. The *DSM* is primarily

descriptive, with little if any attempt to look at underlying causes (Sommers-Flanagan & Sommers-Flanagan, 2007).

Therefore, some mental health professionals are pressured to pick the most severe diagnosis so their clients could qualify for agency services or insurance reimbursement. This is further complicated by just the opposite trend, assigning the least severe diagnosis to avoid stigmatizing and labeling (Feisthamel & Schwartz, 2009). According to Braun and Cox (2005), serious ethical violations can be included, such as asking a client to collude with the assigning of mental disorders diagnosis for services. A client agreeing to this type of practice may be completely unaware of the long-term consequences this misdiagnosis can have regarding present, continued, and future employment, as well as health, mental health, life, and other insurance services or premiums.

Regardless of the reasoning or intent, erroneous diagnoses can harm the clients we serve as well as the professionals who serve them (Feisthamel & Schwartz, 2009). How can professionals be trusted, if this type of behavior is engaged in? It is easy to see how such practices can raise issues related to the ethical and legal aspects that come with intentional misdiagnosing. These practices violate various aspects of the principles of ethical practice in the mental health profession.

Although use of the *DSM* is clearly evident in mental health practice, some professionals continue to question whether it is being utilized properly. For some, such as social workers, the controversy over using this system for diagnostic assessments remains. Regardless of the controversy in mental health practice and application, the continued popularity of the *DSM* makes it the most frequently used publication in the field of mental health. One consistent theme in using this manual with which most professionals agree is that no single diagnostic system is completely acceptable to all. Some skepticism and questioning of the appropriateness of the function of the *DSM* is useful. This, along with recognizing and questioning the changes and the updates needed, makes the *DSM* a vibrant and emerging document reflective of the times. One point most professionals can agree on is that an accurate, well-defined, and relevant diagnostic label needs to reach beyond ensuring service reimbursement. Knowledge of how to properly use the manual is needed. In addition, to discourage abuse, there must also be knowledge, concern, and continued professional debate about the appropriateness and the utility of certain diagnostic categories.

DEVELOPMENT OF THE *DSM* CLASSIFICATION SYSTEM: HISTORY AND RESERVATIONS

The *DSM* was originally published in 1952, with the most recent version, the *DSM-5,* published in 2013. The publications of the *DSM* correspond to the publications of the *ICD,* with an uncertain time frame for the next version of the *DSM,* which will accompany the adopting of the *ICD-11* published by the World Health Organization.

DSM-I *and* DSM-II

The *ICD* is credited as the first official international classification system for mental disorders, with its first edition published in 1948. The APA published the first edition of the *DSM* in 1952. This edition was an attempt to blend the psychological with the biological and provide the practitioner with a unified approach known as the psychobiological point of view. This first version of the *DSM* outlined 60 mental disorders (APA, 1952). In its spiral-bound format, it captured the attention of the mental health community. After the popularity of this first edition, the second edition of the book was published in 1968. Unlike its predecessor, the *DSM-II* did not

reflect a particular point of view; it attempted to frame the diagnostic categories in a more scientific way. Both *DSM-I* and *DSM-II,* however, were criticized by many for being unscientific and for increasing the potential for negative labeling of the clients being served (Eysenck, Wakefield, & Friedman, 1983). The mind-set at the time centered on understanding the mental health of individuals based on clinical interpretation and judgment. From this perspective, symbolic and professional meaningful interpretations of symptoms were highlighted. This perspective relied heavily on clinical interpretation while taking into account the client's personal history, total personality, and life experiences (Mayes & Horwitz, 2005). With their focus on the etiological causations for identified mental disorders, these earliest editions were often criticized for the variance in the clinical and diagnostic interpretation within the categories. The fear of individual interpretation leading to a biased psychiatric label that could potentially harm clients made many professionals cautious. The situation was further complicated by the different mental health professionals who were using this book as a diagnostic tool. Originally designed by psychiatrists, for psychiatrists, the related disciplines in mental health soon also began using the book to assist in the diagnostic process. These other disciplines, as well as some psychiatrists, warned of the dangers of using guides such as the *DSM,* arguing that the differences inherent in the basic philosophies of mental health practitioners could lead to interpretation problems. For example, Carlton (1984) and Dziegielewski (2013) felt that social workers, major providers of mental health services, differed in purpose and philosophical orientation from psychiatrists. Since psychiatry is a medical specialty, the focus of its work would be pathology-based linking with the traditional medical model, a perspective very different from social work, a field whose strengths-based perspective historically has focused on how to help clients manage their lives effectively under conditions of physical or mental illness and disability. (See Quick Reference 1.1 for a brief history of the *DSM.*)

DSM-III *and* DSM-III-R

According to Carlton (1984):

> Any diagnostic scheme must be relevant to the practice of the professionals who develop and use it. That is, the diagnosis must direct practitioners' interventions. If it does not do so, the diagnosis is irrelevant. *DSM-III*, despite the contributions of one of its editors, who is a social worker, remains essentially a psychiatric manual. How then can it direct social work interventions? (p. 85)

These professional disagreements in professional orientation continued, with further divisions developing between psychiatrists and psychoanalysts on how to best categorize the symptoms of a mental disorder while taking into account the professional's theoretical orientations. Some professionals, particularly psychiatrists, argued that there was insufficient evidence that major mental disorders were caused by primarily psychological forces; other psychiatrists, especially those skilled in psychotherapy, and other mental health professionals refused to exclude experience and other etiological concepts rooted in psychoanalytic theory (Mayes & Horwitz, 2005).

Other professionals argued that the criteria for normalcy and pathology were biased and that sex-role stereotypes were embedded in the classification and categories of the mental disorders. They believed that women were being victimized by the alleged masculine bias of the system (Boggs et al., 2005; Braun & Cox, 2005; Kaplan, 1983a, 1983b; Kass, Spitzer, & Williams, 1983;

QUICK REFERENCE 1.1

BRIEF HISTORY OF THE *DSM*

- *DSM-I* was first published by the American Psychiatric Association (APA) in 1952 and reflected a psychobiological point of view.
- *DSM-II* (1968) did not reflect a particular point of view. Many professionals criticized both *DSM-I* and *DSM-II* for being unscientific and for encouraging negative labeling.
- *DSM-III* (1980) claimed to be unbiased and more scientific. Many of the earlier problems still persisted, but they were overshadowed by an increasing demand for use of *DSM-III* diagnoses to to qualify for reimbursement from private insurance companies or from government programs. *DSM-III* is often referred to as the first edition that utilized a categorical approach and in previous research studies was often considered the model for comparison.
- *DSM-III-R* (1987) utilized data from field trials that the developers claimed validated the system on scientific grounds. Nevertheless, serious questions were raised about its diagnostic reliability, possible misuse, potential for misdiagnosis, and ethical considerations.
- *DSM-IV* (1994) sought to dispel earlier criticisms of the *DSM*. It included additional cultural information, diagnostic tests, and lab findings and was based on 500 clinical field trials.
- *DSM-IV-TR* (2000) did not change the diagnostic codes or criteria from the *DSM-IV;* however, it supplemented the diagnostic categories with additional information based on research studies and field trials completed in each area.
- *DSM-5* (2013) presented major changes in diagnostic criteria and highlighted a shift toward a dimensional approach over the previous categorical one.

Williams & Spitzer, 1983). The biggest argument in this area came from the contention that research conducted on the *DSM-III* (1980) was less biased and more scientific.

To address these growing concerns, the *DSM-III* (APA, 1980) was noted as being highly innovative. In this edition, a multiaxial system of diagnosis was introduced, specific and explicit criteria sets were included for almost all of the diagnoses, and a substantially expanded text discussion was included to assist with formalizing the diagnostic impression (Spitzer, Williams, & Skodol, 1980). This edition clearly emphasized the importance of using criteria sets based in observational and empirically based research, disregarding underlying psychic mechanisms and causes (Helzer et al., 2008). This edition was considered an improvement over the earlier versions (Bernstein, 2011); however, even this shift from a psychodynamic perspective to the medical model failed to differentiate between classification of healthy and sick individuals (Mayes & Horwitz, 2005). Therefore, many professionals believed that the earlier problems persisted and that observation data and precise definitions were not really possible, as these criteria generally were not grounded in evidence-based practice principles. However, these concerns about application were overshadowed by an increasing demand for use of the *DSM-III* for clients to qualify for participation and reimbursement from insurance companies and

governmental programs and for the treatment requirements for managed care delivery systems and pharmaceutical companies.

The APA was challenged to address this issue by an immediate call for independent researchers to critically evaluate the diagnostic categories and test their reliability. The developers initiated a call of their own, seeking research that would support a new and improved revision of this edition of the manual, the *DSM-III-R* (APA, 1987). Some professionals who had originally challenged the foundations of this edition felt that this immediate designation for a revised manual circumvented attempts for independent research by aborting the process and making the proposed revision attempt obsolete. Therefore, all the complaints about the lack of reliability concerning the *DSM-III* became moot because all attention shifted to the revision.

The resulting revision, the *DSM-III-R* (1987), did not end the controversy. This edition did, however, start the emphasis on reporting the results of field trials sponsored by the National Institute of Mental Health (NIMH). According to Mayes and Horwitz (2005), these field trials included information from more than 12,000 patients and more than 500 psychiatrists from across the country. These researchers were familiar with the *DSM-II* and had actually participated in its preliminary drafts. Pleased to see the focus on research-based criteria, critics were still concerned that those who did the criteria verification were the same individuals who supported the narrowly defined set of criteria originally identified as the disorder symptoms (Mayes & Horwitz, 2005). Others felt strongly this was a positive step toward using field trials and evidence-based research, which would allow better statistical assessment of incidence and prevalence rates of mental disorders in the general population (Kraemer, Shrout, & Rubio-Stipec, 2007).

Despite these criticisms, *DSM-III* started the trend that was followed in later versions. It outlined a common language for all mental health providers to use and to define mental disorders for professionals using the book, as well as for the systems in which it was to be utilized in the delivery of mental health services for all parties (Mayes & Horwitz, 2005).

The data gathered from these field trials helped to validate the system on scientific grounds while also raising serious questions about its diagnostic reliability, clinical misuse, potential for misdiagnosis, and ethics of its use (Dumont, 1987; Kutchins & Kirk, 1986; Mayes & Horwitz, 2005). Researchers, such as Kutchins and Kirk (1993), also noted that the new edition (*DSM-III-R*) preserved the same structure and all of the innovations of the *DSM-III,* yet there were many changes in specific diagnoses, resulting in more than 100 categories altered, dropped, or added. The complaint noted that no one would ever know whether the changes improved or detracted from diagnostic reliability when comparing the new manual with the old. Attempts to follow up on the original complaints and concerns about the actual testing of overall reliability of the *DSM-III* were not addressed, even after it was published. Specifically, Kutchins and Kirk (1997) continued to question whether these new revised versions still created an environment where diagnosis might be unnecessary or overapplied. Some researchers believe that these complaints may have evolved from a misunderstanding or misapplication of the statistical component of the *DSM* and how it related to the clinical decision making that was to result (Kraemer, Shrout, & Rubio-Stipec, 2007).

DSM-IV

Less than 1 year after the publication of the *DSM-III-R,* the APA initiated the next revision. The *DSM-IV* was originally scheduled for publication in 1990, and the expectation was that it would carry a strong emphasis on the changes that