2 Eight Steps to Diagnosis

Providing your client with a sound diagnosis requires an intentional and thoughtful engagement with a formal diagnostic process. While it can be tempting to turn directly to your DSM and quickly identify a diagnosis that resembles what your client is describing, taking the time to carefully map out your client's symptoms, walking through the steps and arriving at an accurate diagnosis will greatly increase the likelihood that your interventions will be effective. While the process may seem cumbersome in the beginning of your diagnostic career, over time you will find the steps come naturally and will flow easily. It may be helpful to know that after teaching this course for more than 10 years, I have found that students new to the DSM find the manual overwhelming and the diagnostic process daunting. However, with the practice that comes with working weekly with cases, almost without exception, students begin to feel confident about their growing skills and many even find that they enjoy diagnosis, approaching the process like a challenging puzzle to be solved.

In this chapter, we will consider eight basic steps to arriving at a diagnosis as well as 10 essential diagnostic principles. Within this chapter, you will be provided with a discussion of each of these steps as well as illustrative case examples to support your understanding of each step and principle. You will also be given the opportunity to practice steps as you move along through each section. Table 2.01 outlines the eight steps.

Step One: Identify Presenting Problems, Symptoms, and Observations. Symptoms are subjective physical, cognitive, or emotional experiences noticed by the client that cause disturbances in their well-being. Observations, also referred to as signs, may or may not be noticed by the client but are noted by the clinician or intake worker. A client's dress, demeanor, state of mental clarity or confusion and so on are all important observations or signs to be noted by the clinician (Morrison, 2007). The presenting problem is the reason your client has decided to come in for counseling, and usually describes the impact your client's symptoms have on their well-being. The line between presenting problems, symptoms, and clinician observations can be blurry, for instance feelings of depression may

TABLE 2.01   Eight Steps to Diagnosis

Step	Action
Step One	Identify complaints, symptoms, and observations
Step Two	Cluster related symptoms and observations
Step Three	Identify a potential diagnosis or diagnoses
Step Four	Locate the potential diagnoses and their criteria table in the DSM 5
Step Five	Apply relevant diagnostic principles
Step Six	Use the Justification Process (outlined in Chapter 3) to affirm or disconfirm the diagnosis
Step Seven	Write your justification for your diagnosis (outlined in Chapter 3)
Step Eight	Write your coded diagnosis

be the client's primary complaint, included within the symptoms your client describes. Perhaps more important than being able to discern these is cultivating a practice of considering all three and how they relate to one another.

Step Two: Cluster Related Symptoms, Observations, and Presenting Problems. The second step is to cluster the client's symptoms together. When clients present with a lot of symptoms, it is especially important to gain a picture of how these symptoms are related. This is an especially important task in helping you to determine if your client is experiencing more than one disorder. In this way you may ask yourself, "Are all of these symptoms connected or are they somehow arising from different sources or dynamics?" One of the best sources for linking symptoms is your client. Often clients imply or directly state that symptoms are connected or that some symptoms seem unrelated to the others.

Example: For the past several months, Dottie, 82, has not been herself. She explains, "I can't remember the last time I felt this tired. I try to rest but I toss and turn and just

BOX 2.01 CONSIDER THIS

How are you feeling now about this process? What do you anticipate will be challenging? What strengths do you bring to this process?

can't drop into a good sleep. I've been feeling pretty down, too. Throughout the day I spend a lot of time thinking about losing someone close to me. I think of my husband dying or losing my sister and it really bothers me. Sometimes I can't stop thinking about my own death. My daughter says I've been cranky, too." Dottie also notes, "I've lost my appetite completely, but I think that is because of all these damn medications they've got me on. They give me a stomach ache."

Note in Table 2.02 Dottie's counselor has clustered Dottie's symptoms.

TABLE 2.02	Dottie's Concerns and Symptoms Clustered

Dottie's Concerns	Symptoms/Observations
Cluster 1 Concern: Mood: Depression	• Feeling down
	• Thoughts of death (others)
	• Thoughts of death (self)
	• Irritability
Cluster 2 Concern: Bodily Function: Sleep	• Fatigue
	• Difficulty getting to sleep
Cluster 3 Concern: Stomach Upset (client suspects it is a reaction to medication)	• Loss of appetite

Step Three: Identify Potential Diagnoses. The third step is to identify a list of potential diagnoses for each cluster of symptoms. In order to arrive at potential diagnoses, you will want to first consider the diagnostic dimensions that seem to capture some or all of your client's symptoms. Past editions of the DSM have included decision trees, flow charts that served to guide the decision-making process in identifying potential diagnoses; however, these have been dropped from the current edition of the DSM. With time you will gain a familiarity with the DSM and you will be able to readily identify the dimensions of the manual that are most relevant to your client. If this is your first introduction, however, you may find Tables 2.03 and 2.04 to be helpful.

In Table 2.03, Dimensional Table of Diagnoses, the dimensions have been organized for you. You will notice that the left-hand column offers a question about your client's primary concern and the right-hand column matches that concern with diagnostic dimensions of the DSM. Table 2.04 lists the Dimensions and a brief description of select disorders.

For example, Trent, 15, has been trying to stop picking at his many moles for about a year. But when he finishes his shower each evening and begins to dry off, he notices the moles and begins again to pick at them, often causing them to bleed. This habit has sometimes led to an infection. His body is now covered with small scars that have

BOX 2.02 TRY THIS: IDENTIFY SYMPTOMS, OBSERVATIONS, AND PRESENTING PROBLEMS

Read through the following example and identify the information that you would describe as a symptom, those which are observations and those that are complaints/presenting problems.

Joel. Upon entering the counselor's office, the clinician noticed immediately that Joel, age 34, was dressed for warm weather despite the snow falling outside the clinic's office window. Joel's long hair fell in greasy strands over his shoulders. He seemed unaware that his baggy shorts were unzipped. Joel, nearly 20 minutes late, explained he had a lot of difficulty getting out of bed that morning and had thought of skipping the appointment since he had

been unable to sleep much in the past several weeks; he complained of feeling foggy and tired. He described being constantly bothered by a voice narrating his actions. Joel was recently laid off of his part-time job and shared that he was "desperate" to get some work.

- What are Joel's presenting problems/complaints?

- What are Joel's symptoms?

- What key observations has the clinician made about Joel's presentation?

resulted from his tendency to pick at his moles. Trent notes, "I try and try to stop but something keeps driving me to pick and pick."

Using Table 2.03, we can quickly identify a potential diagnosis for Trent. First, looking in the left-hand column, we note that Trent's problem is not one of cognition or of mood; it is a behavior that he would like to stop. Turning to the column to the right, we can further narrow his potential diagnosis by noting that his difficulty is not one of disruptive or impulsive behavior but instead it is a compulsive one, since he feels compelled and admits he can't stop without help.

Again, narrowing your diagnosis further, move to Table 2.04, and use the left-hand column to locate "compulsive behavior," and note that in the column on the right three potential diagnoses are offered: obsessive compulsive disorder (OCD), trichotillomania and excoriation disorder. Were you to try to diagnose Trent, you would then look at each of these diagnoses in the DSM to discover which of these is the more appropriate for Trent.

Once you have identified your client's primary concern or concerns and a potential diagnostic dimension for each concern, Table 2.03 will help you in narrowing your search to one or more potential diagnoses. In examining our example of Sarah, using the table above, it seems her primary concern is one of mood. In examining the potential diagnostic dimensions, in the right-hand column, the best fit seems to be the bipolar dimension, since her concern is not anxiety related nor one primarily of low mood

TABLE 2.03	Primary Concern and Potential Diagnostic Dimensions

Primary Concern	Potential Diagnostic Dimensions
Cognitive Is your client's primary concern one that pertains to the way your client thinks or learns?	• *Neurodevelopmental*: began in early childhood and affects learning • *Dissociative:* leaves your client feeling out of touch with him or herself or as if in a dream • *Schizophrenia and Related:* client experiences odd beliefs that are distressing to him or her • *Obsessive Compulsive:* thoughts are intrusive/unwelcome and cause distress • *Neurodegenerative:* thinking, learning or memory are impaired due to injury or illness
Mood Is your client's primary concern related to emotional states?	• *Anxiety:* worries, fears and phobias • *Depression:* low mood and melancholy • *Bipolar:* extremes of mood; mania or hypomania have been present
Behavior Is your client's primary concern related to behavior?	• *Disruptive, Impulse Control and Conduct*: the behavior is disruptive to others, impulsive, does not match developmental expectations, harms others or violates their rights • *Compulsive Behavior:* behavior is compulsive, sometimes used to stave off some feared event • *Substance and Addiction*: Behavior is compulsive and involves a substance or addictive interaction • *Eating:* eating is restricted, excessive or consumption causes harm or distress • *Neurodevelopmental:* Behavior is stereotyped, self-soothing or self-harming (Autism) or impulsive, non-rhythmic and repetitive • *Paraphilic:* sexual behaviors with children, or sexual behaviors harmful or distressing to self or others or that violates the rights of others
Bodily Function Is your client's primary concern related to the body or basic functions such as eating, sleeping or sexual function?	• *Eating:* eating is restricted or excessive, or causes harm or distress • *Elimination:* difficulties with control of elimination functions • *Sexual:* Difficulties obtaining satisfaction in sexual experiences • *Sleep:* difficulty obtaining or maintaining satisfactory sleep states
Identity/Personality Is your client's primary concern related to gender or patterned ways of relating to themselves and others?	• *Gender:* a sense that one's physical body is not in harmony with one's identified gender • *Personality:* patterns and ways of being in the world create predictable difficulties for self and other in interpersonal and intrapersonal experiencing

BOX 2.03 TRY THIS: IDENTIFYING A POTENTIAL DIAGNOSIS FOR SARAH

In the following case example, use Tables 2.03 and 2.04 to identify a potential diagnosis or diagnoses for Sarah.

Example: Sarah, age 25, has experienced significant mood swings over the past 4 years, including prolonged low mood and shorter periods of elevated mood. She was recently hospitalized after attempting suicide, and is now attending a partial hospitalization program.

1. What are Sarah's primary concerns?

2. Consult Table 2.03. Is Sarah's concern primarily cognitive, mood, behavior, bodily function or identity?

3. In consulting Table 2.04, what potential disorders might Sarah be grappling with?

but of fluctuations in mood. Our next step is to identify one or more specific diagnoses that might be a good fit for Sarah and then to turn to those diagnostic tables in the DSM 5. In consulting Table 2.04, and using the left-hand column, finding Mood and skipping down to Bipolar, thanks to our previous step, we can now look to the right and see three potential diagnoses for Sarah: Bipolar I, Bipolar II and Cyclothymic disorder.

Step Four: Locate the Diagnosis and Its Criteria Table in the DSM. After using Table 2.04 to locate potential diagnoses, using the DSM 5's index locate the diagnostic criteria table and discussion of that disorder. For additional support in narrowing potential diagnoses within a dimension, you may want to use the pivot tables located in this book. Pivot tables contain questions (pivot points) that will help you to turn your attention to potential diagnostic options. A pivot table has been provided for you for each diagnostic dimension in the DSM, a sample, the OCDs pivot table, is provided in Table 2.05.

Step Five: Apply Relevant Diagnostic Principles. Once you have identified a diagnosis or diagnoses that seem to be a good fit, you will want to refer to key diagnostic principles. Diagnostic principles are guidelines and best practices that support strong diagnostic decision-making. You will find 10 diagnostic principles discussed at the end of this chapter.

TABLE 2.04 **Diagnostic Concerns and Matching Diagnoses**

Concerns: Diagnostic Dimensions	Potential Diagnoses
Cognitive	
• *Neurodevelopmental:* began in early childhood and affects learning	• Learning Disorders; Intellectual Disability; Attention-deficit/hyperactivity disorder (ADHD); Autism
• *Dissociative:* leaves your client feeling disconnected from self or as if in a dream	• Dissociative Identity Disorder; Dissociative Amnesia; Depersonalization/Derealization
• *Schizophrenia and Related:* client experiences odd beliefs that your client finds distressing	• Schizophrenia; Delusional Disorder; Brief Psychotic Disorder; Schizophreniform Disorder; Schizoaffective Disorder
• *Obsessive Compulsive:* thoughts are intrusive/unwelcome, compulsive and cause distress	• Obsessive compulsive disorder (OCD); Body Dysmorphic Disorder; Hoarding
• *Neurodegenerative*: thinking, learning or memory are impaired due to injury or illness	• Major and Minor Neurocognitive Disorders, such as Alzheimer's, Parkinson's, Huntington's, etc.
Mood	
• *Anxiety:* worries, fears and phobias	• Separation Anxiety, Social Anxiety, Selective Mutism, Specific Phobia, Panic Disorder, Agoraphobia
• *Depression:* low mood and melancholy	• Disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder, premenstrual dysphoric disorder
• *Bipolar:* extremes of mood; mania or hypomania have been present	• Bipolar I, Bipolar II and Cyclothymic Disorder
Behavior	
• *Disruptive, Impulse Control and Conduct:* the behavior is disruptive to others, impulsive, does not match developmental expectations, harms others or violates other's rights	• Oppositional Defiant Disorder; Intermittent Explosive Disorder; Conduct Disorder; Pyromania; Kleptomania
• *Compulsive Behavior*: behavior is compulsive often used to stave off some feared event	• OCD; Trichotillomania; Excoriation
• *Substance and Addiction:* Behavior is compulsive and involves a substance or addictive interaction	• Variety of substance disorders
• *Eating:* eating is restricted, excessive or consumption causes harm or distress	• Anorexia Nervosa; Bulimia Nervosa; Pica; Avoidant/Restrictive Intake
• *Autism:* Behavior is stereotyped, self-soothing or self-harming	• Autism Spectrum Disorder
• *Motor Tics:* involuntary motor or vocal experiences	• Tourette's Disorder; Persistent Motor or Vocal Tic Disorder
• *Paraphilic:* sexual behaviors with children, or is harmful or distressing to self or others or that violates the rights of others	• Voyeuristic Disorder; Exhibitionistic Disorder; Frotteuristic Disorder; Sexual Sadism; Pedophilic Disorder; Fetishistic Disorder; Transvestic Disorder

Concerns: Diagnostic Dimensions	Potential Diagnoses
Bodily Function	
• *Eating:* eating is restricted or excessive or causes harm or distress	• Pica; Rumination Disorder; Avoidant/Restrictive Food Intake Disorder; Anorexia Nervosa; Bulimia Nervosa; Binge-Eating Disorder
• *Elimination:* difficulties with control of elimination functions	• Enuresis; Encopresis
• *Sexual:* Difficulties attaining satisfaction in sexual experiences	• Delayed Ejaculation; Erectile Dysfunction; Female Orgasmic Disorder; Female Interest/Arousal Disorder; Geno-Pelvic Pain/Penetration Disorder; Male Hyposexual Desire Disorder; Premature Ejaculation
• *Sleep:* difficulty attaining or maintaining	• Insomnia Disorder; Hypersomnolence Disorder; Narcolepsy; Obstructive Sleep Apnea Hypopnea; Central Sleep Apnea; Sleep-Related Hypoventilation; Circadian Rhythm Sleep–Wake Disorders; Non-Rapid Eye Movement Sleep Arousal Disorders; Nightmare Disorder; Rapid Eye Movement Sleep Behavior Disorder; Restless Leg Syndrome
Identity/Personality	
• Gender Dysphoria: distress that arises from the mismatch between one's assigned gender and one's own self-identified gender	• Gender Dysphoria in Children; Gender Dysphoria in Adolescents and Adults
• Personality Disorders: entrenched patterns of relating to self and others that differ markedly from the expectations of that individual's cultural contexts	• Paranoid Personality; Schizoid Personality; Schizotypal Personality; Antisocial Personality; Borderline Personality; Histrionic Personality; Narcissistic Personality; Avoidant Personality; Dependent Personality; Obsessive Compulsive Personality

Diagnostic Steps Six, Seven and Eight

Steps six and seven make use of the Justification Process, which is outlined more fully in Chapter 3. This process and the written format of your justification will support the expression of clear diagnostic rationale for each diagnosis that you give. The justification process may also serve as documentation in your clinical notes or support clear communication with other healthcare professionals working with your client. Using this process may also serve to interrupt some forms of bias by encouraging clinicians to carefully consider all information presented and to reduce diagnoses based on assumptions (Hammond, 2015).

Step Eight: The Diagnostic Notation. The final step is to make your diagnostic notation. The notation is made up of the code, name of the diagnosis and any relevant specifiers. Recall that the codes located in the DSM 5 reflect the International Classification of Diagnoses (ICD) coding system used by the World Health

Organization. The ICD has historically been updated more frequently than the DSM so the print edition of the DSM 5 contains some outdated codes. The bolded code, reflecting the ICD 9, is no longer in use. Refer instead to the code within the parenthesis, shown in grey font in the DSM criteria tables; this reflects the ICD 10 code. Some of the codes, but not all, have been updated with the publication of the ICD 11; always check the most recent DSM 5 Supplement, available on the American Psychiatric Association (APA) website for any updated coding or changes in criteria. New supplements seem to be released in October each year.

When noting a diagnosis with its code, use the following format:

1. First list the most recent ICD code, being sure to check supplements for updates.

2. Next, list the name of the diagnosis, capitalizing only the first word of its name.

TABLE 2.05	Sample Pivot Points Table: Obsessive Compulsive Disorders

	Consider
Pivot Point One: Does your client's suffering arise from intrusive, repetitive and distressing thoughts or from irresistible and unwelcome rituals?	*Obsessive Compulsive Disorder*
Pivot Point Two: Does your client's suffering arise out of grossly distorted or incongruent perceptions of the body?	
• Is your client's distorted body image related to an exaggerated or perceived physical flaw?	*Body Dysmorphic Disorder*
• Is your client's distorted body image related primarily to weight?	*Anorexia Nervosa*
• Is your client's distress about the body? Are they embedded in a feeling of incongruence between gender identity and the physical body?	*Gender Dysphoria*
Pivot Point Three: Do your client's distressing thoughts and compulsions manifest in an inability to let go of objects that have lost their functional value and create a cluttered and unsafe environment?	*Hoarding Disorder*
Pivot Point Four: Do your client's compulsions manifest in sounds or movements that your client can't control (tics)?	*Tic Disorders*
Pivot Point Five: Does your client experience distress as a result of an irresistible urge to pull out their hair?	*Trichotillomania*
Pivot Point Six: Does your client experience distress as a result of an irresistible urge to pick their skin?	*Excoriation Disorder*

Using the pivot table above, which diagnosis or diagnoses would you like to explore further in order to reach a diagnosis for Spencer?

BOX 2.04 TRY THIS: SPENCER

Read through the following case then refer to the pivot table above. As you consider each question in the pivot table, ask yourself, whether or not the question fits the case description well. When you can answer positively, look to the right-hand column for a possible diagnosis. Once you have identified one or more potential diagnoses, explore each for a possible fit with Spencer's concerns and symptoms by turning to its diagnostic criteria table in the DSM 5. Once you have read through the related diagnostic criteria table or tables, remember to turn to the alternative diagnoses section that follow the criteria table in the DSM and consider other similar diagnoses that may be a better fit.

Spencer. Spenser, age 36, has been struggling for years with feelings of low self-worth and isolation. He works from home for a tech company. While he describes himself as an introvert and once appreciated the low social demands that came with this job, he now feels isolated from others and longs for social connection. While Spencer believes he is talented in his work and could find a position easily, he is held back from applying for a position by his "looks." Spencer believes that his nose and chin are "grotesque." Though his friends and family members have tried to convince him that there is nothing unusual in either the size or the shape of his nose or chin, Spencer has had three plastic surgeries to try to correct the problems he perceives. Spencer estimates that he spends several hours a day distracted by the "ugliness" of his nose and feels sure it will prevent him from finding a partner.

3. Finally, list all relevant specifiers, using all lower-case letters. Separate each specifier with a comma.

Example: F50.2 Bulimia nervosa, in partial remission, mild

When No Diagnosis Fits Comfortably. Frequently our client's concerns and symptoms do not fit neatly into the descriptions provided with the diagnostic tables, but our client is clearly suffering and is in need of support. The DSM 5 provides two options for situations in which diagnosis seems appropriate or necessary but the client's symptoms are atypical: specified or unspecified categories. Within each dimension are criteria tables for unspecified manifestations. This designation is used when the general dimension of suffering is known but very little additional information is available, or the clinician has chosen not to describe the symptoms at the time of diagnosis. The second option is to use the other specified criterion table located at the end of each dimension chapter. These offer atypical presentations of the dimension. For example, on page 353 of the DSM 5, other specified feeding or eating disorder, offers five atypical presentations, such as atypical anorexia.

Coding Deferral, Provisional and Rule-Outs. Often, we are faced with situations in which the diagnostic picture is unclear for one reason or another and despite following the eight steps, we cannot give a diagnosis with any real certainty, and the specified and unspecified tables are not a good fit. In these situations, we have several options.

The first to consider is a diagnostic deferral. Defer the diagnosis when it seems that diagnostic criteria are not met for a diagnosis; for instance, when the duration of your client's depression is too short to describe a major depressive episode. For situations in which symptoms strongly suggest a particular diagnosis but more information is needed to confirm the diagnosis, use a provisional diagnosis (APA, 2014). This is generally done by writing out the code and then the name of the diagnosis followed by the word *provisional*.

In situations in which you are discerning between two diagnoses, consider using the term *rule out* to note an alternate, but perhaps less likely, diagnosis that is still under consideration. Though it may be counter-intuitive, *rule out* indicates that the clinician

BOX 2.05 TRY THIS: IDENTIFY THE UPDATED DIAGNOSTIC CODE

Using the DSM 5 Supplement, identify the updated code for the following:

- F63.3 Kleptomania
- F64.1 Gender dysphoria
- F 42 Hoarding disorder

BOX 2.06 TRY THIS: IDENTIFY THE CORRECTLY FORMATTED DIAGNOSES

Box 2.06 Below find five examples. Identify which of the following is written in the correct format and change those that are incorrect into its correct notation:

- Nightmare Disorder (F51.5), During Sleep Onset, Severe
- 307.53 (F98.21) Rumination Disorder, in remission
- F44.81 dissociative identity disorder
- F45.22 Body dysmorphic disorder, with poor insight
- 312.81 Conduct Disorder, (F91.1) Childhood-onset type, unconcerned about performance

needs more information and is still in the process of considering a diagnosis and not that the clinician is sure that this diagnosis is not at play. It is worth noting that the DSM has dropped the term rule out from the manual, though it retains the term provisional (APA, 2014).

The Use of Questions. In the three examples above, diagnosticians should consider listing the specific questions that will lead them to either solidify a diagnosis, as in example 2, or to clearly distinguish between two competing diagnoses, as in example 3

BOX 2.07 NOTATION OF DEFERRED AND PROVISIONAL DIAGNOSES: EXAMPLES

Example 1: In the following example, the clinician does not have enough information to offer a diagnosis and has judged that listing a provisional diagnosis is inappropriate due to significant gaps in information.

F84.0 Autism spectrum disorder, without accompanying intellectual impairment, without accompanying language impairment, diagnosis deferred

Example 2: In the following example, the clinician's notation indicates that she intends to gather more data to support her strong suspicion that her client is struggling with autism and anticipates confirming this diagnosis after formal testing:

F84.0 Autism spectrum disorder, without accompanying intellectual impairment, without accompanying language impairment, provisional

BOX 2.08 THE RULE OUT NOTATION: EXAMPLE

In the following example, the clinician has only enough information to diagnose a communication disorder but is concerned that the problem may in fact be an autistic spectrum disorder:

F80.89 Social (pragmatic) communication disorder; Rule out F84.0 Autism spectrum disorder, without accompanying intellectual impairment, mild

or to determine that no diagnosis is needed. Listing these questions serves two important purposes. First it provides prompts or reminders for clinicians in their follow up sessions. Second, and as importantly, listing these questions and, later, their answers, adds clarity, transparency and documentation to your diagnostic process. These questions should be maintained in your clinical notes.

The following process and format may be helpful in structuring the inclusion of questions in your notes. First, document any diagnostic questions that remain. Then note how the answer to that question will influence your decision. Box 2.12 on page 40 offers an example of how a clinician has used questions to support and document her diagnostic decision-making process.

When no diagnosis is being made. When through your careful clinical judgment, it is not necessary or appropriate to give a diagnosis, the APA website, 2013, recommends that you note this in the following way: V71.09 No diagnosis given.

The preceding eight steps help to create a strong practice in diagnostics. However, some outside pressures can intrude on the diagnostic process and impinge on ethical diagnostic practices. First among these problems are pressures to document a diagnosis early in the therapeutic relationship. Systems of managed care, for example, can require that a diagnosis be given before a client's treatment can be reimbursed. Similarly, some agency settings require a diagnosis be given in the first session. These outside demands can hinder diagnosticians in their efforts to take the time needed to diagnose complex presentations carefully and accurately. Another impediment to strong and ethical diagnostic practice is fostered by insurance policies that limit the types of disorders that are covered, tempting clinicians to misdiagnose in order to assure that a client's treatment is covered. When clinician's give clients a diagnosis that is not warranted by the client's symptoms, this is known as "up-coding." Up-coding sometimes happens when clinicians want to assure that a client receives needed services but their symptoms don't fully meet the diagnostic criteria, a presentation described as "sub-threshold," when the presentation blends two or more diagnoses but fits neither well, or when symptoms fluctuate, sometimes meeting and sometimes not meeting criteria, but still requiring intervention (Cartwright et al., 2017). Up-coding can have a number of consequences for clients, for instance, it may shift how clients understand themselves and is but one of many contributions to diagnostic inflation (Frances, 2013b).

When More than One Diagnosis Is Needed. It is not uncommon for a client to carry two or more diagnoses at the same time. A number of diagnoses tend to appear together. For example, 75% of people struggling with depression also experience sleep difficulties, 40% experience hypersomnia (Nutt et al., 2008). Similarly, in one 2008 study, 84% of participants diagnosed with autism also carried at least one other diagnosis; 29.2% of study participants also carried a diagnosis of social anxiety disorder, and 28.1% held an oppositional defiant diagnosis (Simonoff et al., 2008). How do you diagnose and code more than one diagnosis?

Four terms are used to describe situations in which more than one diagnosis is needed or used: comorbid, co-occurring, multiple diagnosis and dual diagnosis. For

BOX 2.09 THE USE OF QUESTIONS IN DOCUMENTATION OF THE DIAGNOSTIC PROCESS

Example 1: It is unclear if Adam's interests fully meet criteria for B3 of the autism diagnosis or are simply a topic of captivation about which he holds a great deal of knowledge.

If his interests rise to the level of a restricted and fixated interest: *DX F84.0 Autism spectrum disorder, without accompanying intellectual impairment*

If his interests don't rise to the level of restricted interest: *DX F80.89 Social (pragmatic) communication disorder*

many clinicians, but not all, the term dual-diagnosis is used to describe a situation in which a client has been diagnosed with both a substance use disorder as well as a companion mental health disorder. For other clinicians, this term is simply used to describe two or more diagnoses that exist at the same time. Co-occurring disorders are those disorders that arise at the same time but are happenstantial to one another and not causal or directly linked. For example, when a client has chicken pox and also a broken arm, this situation is very unfortunate but the two are not causal to one another. Similarly, an eating disorder and depression may exist independently of one another in the same client. Comorbid disorders, on the other hand, imply that there is a relationship between the two distinct disorders, for instance, a client who has developed agoraphobia and has been unable to leave the house as a result, and gradually develops all the symptoms of a major depressive disorder thanks to feelings of helplessness and isolation. The problem of determining what mental health disorders are co-occurring and which are comorbid can be very difficult to parse, and some have argued that when describing mental health disorders, the difference may be specious at its base (Kaplan et al., 2006). I've noticed that many clinicians and researchers use these terms interchangeably; as language evolves, these terms may eventually come to refer to the same dynamic.

In the following section, you will be introduced to diagnostic principles that will serve to guide you in making diagnostic decisions when complexities arise, as they are bound to.

BOX 2.10 DOCUMENTATION OF "NO DIAGNOSIS"

When no diagnosis is being given, code in this way:
   V71.09 No diagnosis given

Diagnostic Principles and Considerations

Morrison (2007) in his now classic text *Diagnosis Made Easier* outlines a number of guiding principles that work to provide direction in the process of identifying an appropriate diagnosis. Allen Frances (2013a), in *Essentials of Psychiatric Diagnosis*, also provides principles for arriving at a sound diagnosis, which he describes as "steps."In the following pages, I have consolidated Morrison's and Frances' principles and reorganized them into two primary themes: clinical significance, and differential diagnosis.

Clinical Significance

At times, we are faced with a decision about whether or not a diagnosis is appropriate or needed. Ethically, clinicians are bound to avoid applying a diagnosis when one is not necessary or when a diagnosis might be harmful to the client. In instances in which a clinician is discerning whether or not a diagnosis should be applied, principles one, two and three can be helpful.

   Principle 1: The Warranted Concern. This principle is one that guides us to offer a diagnosis only when thinking, emotional distress or behavior significantly impairs functioning, or impinges on the rights or welfare of others, and is outside of the client's cultural expectations. This principle is so important that each diagnostic table in the DSM 5 contains a reminder to examine the symptoms or behavior and to confirm that they result in clinical levels of distress or impairment in social or occupational functioning before diagnosing. This criterion is designed to prevent unnecessary diagnoses and the diagnosis of culturally sanctioned responses to stress, trauma or grief. Frances (2013a) offers an additional recommendation and advises clinicians to be patient in assessing signs and symptoms and to avoid diagnosing early in the therapeutic process where possible, as symptoms may be at their most intense when your client decides to seek help but may quickly soften or ease afterward. Signs and symptoms that are considered for diagnosis should be significant and persistent. It is helpful to remember

that being unhappy or dissatisfied with one's life is not the same as having a mental illness.

Battling Diagnostic Inflation and Misdiagnosis. Diagnostic inflation describes the trend to fold normal feeling states and behaviors into diagnostic categories and generally refers to a pattern of treating normal or expected responses with psychiatric medications, but also includes diagnostic trends or fad diagnoses. For example, prior to 1979 only 76 people had been documented to display more than one personality; however, in the decade following the inclusion of the multiple personality diagnosis in the DSM III and two popular movies featuring the disorder, more than 40,000 cases were diagnosed (Acocella, 1999; Piper & Merskey, 2004). Similarly, when the DSM IV-TR was published, the incidence of autism was estimated to be one in 250 births; however, in a 2018 survey of more than 50,000 participants, one in 40 parents reported having a child diagnosed with the disorder (Kogan et al., 2018). Our diligence in diagnosing only those concerns that are not typical responses to the stressors that come with living, and carefully applying appropriate and well-reasoned diagnoses serve an essential function in quelling trends toward inflating diagnostic numbers (Batstra & Frances, 2012; Frances, 2013b).

Principle 2: Life span Development. A second key diagnostic consideration is the principle of life span development. When applying this principle, we consider the fact that certain expressions of feelings, thoughts and behaviors may be expected and even appropriate at one stage of the life span but infringe on functioning at another. We see an example of this in the early stages of toddler development in which separation anxiety is a typical and expected part of cognitive and emotional development as well as a positive signal of secure attachment. During this stage, children show tremendous reluctance and even fear when leaving their mother's sight and may cry and cling when separation is anticipated. However, in a child age 7, for instance, this type of responding is not typical and may seriously impair a client's ability to go to school or to feel comfortable and safe when away from parents. In the case of the 7 year old, if the response is prolonged, pervasive and causes difficulties in the child's ability to socialize or go to school, a clinician will want to consider whether or not the child is experiencing a separation anxiety disorder (APA, 2014; Ehrenreich et al., 2008). When making use of this principle, it is important to remember to consider the client's approximate developmental stage rather than chronological age. For clients with a cognitive impairment, for example, certain behaviors may be developmentally appropriate after accounting for delays in development (APA, 2014; Frances, 2013a; Morrison, 2007).

Principle 3: Culturally Informed Responding. We live in a diverse world where our unique beliefs and experiences frame our thoughts, feelings and behavior as well as our understanding of and relationship to those thoughts, feelings and behaviors. Consequently, in determining whether or not a set of symptoms meet the level of clinical significance, we must also take into consideration the intersection of the client's cultural identities (ethnicity, race, gender, sexual orientation, socioeconomic class,

TABLE 2.06	10 Diagnostic Principles
Clinical Significance	
	The Warranted Concern
	Life span Development
	Culturally Informed Responding
Differential Diagnosis	
	Horses and Zebras
	The Principle of Predominance
	Occam's Razor or the Law of Parsimony
	Caution in Crisis
	Unaccounted for Symptoms
	Contributing Factors
	Client Resonance

Source: Adapted from Morrison, J. (2007) and Frances, A. (2013).

first language etc.) with the problem itself (APA, 2014; Frances, 2013a; Hays, 2008). Asking ourselves the following questions helps prevent misdiagnosis based in bias or lack of information:

- "How does my client's cultural background inform the way that they are experiencing this problem?"

- "Is this response typical and expected given this set of beliefs, cultural experiences or practices?"

The answers to these questions will take time and constitute an investment in your cultural competence when working with clients different from yourself. We will explore cultural considerations for each dimension throughout this text.

Differential Diagnosis. Often, we are faced with clients who present with symptom sets that are complex, layered or don't fit well into the descriptions outlined in the diagnostic tables. When reflecting on your own life experiences, you may be able to recall times when you have experienced feelings that seemed to conflict, feelings of relief, regret and sadness all mixed in together, for instance. Our human capacity

BOX 2.11 DEFINITION BOX: PRINCIPLE 1: THE WARRANTED CONCERN

The concern must cause distress and impairment to be diagnosed.

BOX 2.12 PRINCIPLE 2: LIFE SPAN DEVELOPMENT

Consider your client's social and cognitive development. Do not diagnose difficulties that might be expected thanks to typical developmental conflicts or challenges.

for feeling, thinking and behavior is nearly limitless, and so are the possibilities for client presentations and symptom sets. The physical structure of the human brain is extremely complex, and disruptions, injury and illness can result in a vast combination of potential difficulties within the organ of the brain itself. Very often, we will be able to find a shorthand for our clients' concerns within the DSM 5, but for some clients, these descriptions will not be an easy or tidy fit. Principles 4, 5 and 6 can be helpful in finding a more comfortable diagnosis for these clients.

Principle 4: Horses and Zebras or the Principle of Commonality. Imagine you were sitting in a café in downtown Manhattan enjoying a cup of coffee with a friend when you heard the sound of hooves clopping in the street. As you glance out the window, would you expect to see a horse or a zebra? Morrison (2007) points out that with a few exceptions, most of us expect to find a horse or horses trotting down the street and expect to see a zebra only in the zoo or on safari. When faced with a choice between

BOX 2.13 PRINCIPLE 3: CULTURALLY INFORMED RESPONDING

Give careful consideration to your client's culture and identities. Do not diagnose culturally sanctioned thoughts, feelings or behavior. Maintain awareness of trends in diagnosis that either exclude or overdiagnose populations.

BOX 2.14 PRINCIPLE 4: HORSES AND ZEBRAS OR THE PRINCIPLE OF COMMONALITY

This principle cautions clinicians to take care when considering rarely seen diagnoses or when diagnosing very uncommon presentations of a disorder.

BOX 2.15 PRINCIPLE 5: THE PRINCIPLE OF PREDOMINANCE

The principle of predominance reminds us that some disorders hold within them all the criteria for other less pervasive disorders; in these cases, diagnose only the predominant diagnosis.

two diagnoses, one common and one relatively uncommon, this principle advises that the safer diagnosis is the more common of the two. This principle can be applied by asking which of the two diagnoses is more common, and thus more likely, but can also be applied in examining the client's presentation by asking, "Does this case reflect a more common presentation of one diagnosis than another?" In other words, occasionally, a presentation may look like two disorders but reflects a more typical presentation of one disorder than another.

By way of example, children with attention-deficit/hyperactivity disorder (ADHD) struggle with attention and with high activity levels. However, the consequence of this distraction and frenetic activity frequently results in difficulties noticing cues in the social environment which, in turn, prevents them from responding to those cues. Children with autism share these difficulties in seeing, interpreting and responding to social cues. While both children with ADHD and children with autism spectrum disorder (ASD) struggle with social cues, they struggle for different reasons. A child with high functioning autism and a child significantly impacted by ADHD can have very similar presentations. ADHD, however, is five times more common than autism (APA, 2014), and may be the more appropriate choice if the child's presentation is very cloudy, particularly if given with a rule out for ASD.

Principle 5: The Principle of Predominance. The principle of predominance helps to reduce the potential for multiple and unnecessary diagnoses. A number of diagnoses are pervasive in their nature, affecting thought, emotion and behavior. Schizophrenia and autism are classic examples of disorders that come with far-reaching consequences. Diagnosticians who fail to observe the principle of predominance may find themselves offering a veritable submarine sandwich of diagnoses to persons suffering from Schizophrenia, for example, ranging from Delusional Disorder, Brief Psychotic Disorder, Major Depressive Disorder, Generalized Anxiety Disorder, Derealization/Depersonalization Disorder and so on. The principle of predominance reminds us that some disorders hold within them all the criteria for other less pervasive disorders. It is only necessary to diagnose those additional disorders that are not adequately described by the primary or predominant diagnosis and those that may not resolve with the treatment of the primary concern (Morrison, 2007).

Often, however, it is necessary to diagnose more than one disorder at a time. This process can be a bit complicated; however, as it is not always immediately evident whether two disorders are working independently, such as with a person struggling with schizophrenia also abuses substances as a way of responding to the symptoms of the psychotic disorder, or if a single disorder is generating symptoms that also mimic a second disorder, such as when a client in the end stages of an alcohol use disorder exhibits symptoms consistent with a psychotic disorder. When trying to determine whether or not to diagnose two disorders at the same time, the following principles will be supportive in your diagnostic process.

Principle 6: Occam's Razor or the Law of Parsimony. The principle of Occam's Razor states that when we must choose between two competing answers it is best to choose

BOX 2.16 PRINCIPLE 6: OCCAM'S RAZOR OR THE LAW OF PARSIMONY

Choose the diagnosis that requires the fewest assumptions.

the answer that requires the fewest assumptions (Morrison, 2007). When applying this principle to a case, take note of what information you can verify and what information is reliant upon inference or assumption. Keeping this distinction in mind will also help support you in avoiding diagnoses based heavily on assumption or, worse, bias.

Principle 7: Principle of Caution in Crisis, Transition and Personality Concerns. There are moments in a person's life that naturally bring about elevated states of anxiety, distressed behavior or thinking. Many readers can attest to experiences like this during the early weeks of the pandemic and the quarantines that were mandated across the country, for example. Difficult situations often require a bit of time before people feel they have their legs under them again, and can return to their baseline state. A diagnosis will be more accurate when the crisis has begun to settle and the clinician is better able to gauge the client's functioning and well-being (Frances, 2013a; Morrison, 2007). Clinicians are ill advised, for example, to diagnose a child shortly after a parent's military deployment. This period of adjustment can cause very high levels of stress and foster or elevate behaviors that make diagnosis difficult at best. Other critical situations, such as immediately following a catastrophic loss or a natural disaster, are not good times for accurately assessing and diagnosing client concerns at any age. Clients with an untreated primary diagnosis can display symptoms consistent with a personality disorder but do not display those symptoms once treated successfully for the primary diagnosis. Best practices advise extreme caution when diagnosing clients with a personality disorder during a time of significant crisis since very stressful moments can escalate symptoms and may then resemble a personality disorder (Morrison, 2007).

Principle 8: Unaccounted for Symptoms. This principle reminds us to examine the client's concerns for symptoms that have not been captured within the primary diagnosis (Morrison, 2007). For instance, consider a client diagnosed with separation anxiety who also complains of regular nightmares over the past year. While anxiety may underlie these dreams, the separation anxiety disorder likely does not adequately account for

BOX 2.17 PRINCIPLE 7: PRINCIPLE OF CAUTION IN CRISIS, TRANSITION AND PERSONALITY CONCERNS

This principle reminds us to use caution and allow sufficient time before applying a personality disorder diagnosis.

the nightmares. What's more, the nightmares may continue without separate intervention. In this case, careful consideration of an additional diagnosis of a nightmare disorder should be made if the nightmares do not seem to respond to treatment of the anxiety.

Principle 9: Contributing Factors. This principle reminds us to keep in mind the possibility of an underlying medical condition, particularly in the elderly. Also essential is to consider the possibility that substance use may be creating or exacerbating mental health symptoms. Include within your consideration any prescribed medications, many of which have side effects that mimic mental health concerns (Atkins, 2014; Frances, 2013a; Morrison, 2007).

Principle 10: Client Resonance. At times, it may be unclear if a set of symptoms is entirely accounted for by a primary diagnosis or should be considered to be part of a diagnosis of their own. For instance, sleep disturbances are very common in major depressive disorder. It is important for a clinician to consider whether or not the sleep disturbance is a concern that requires separate treatment. This principle suggests that we can turn to our clients for these answers by asking clients how they experience the relationship between their symptoms. For example, you might ask:

- "Do these sleep difficulties feel like they are part of the depression you describe, or do they feel separate to you?"

- "Do you have a sense that if the depression resolved that your sleep would stabilize or is this something we should work on independently of the depression?"

BOX 2.18 PRINCIPLE 8: UNACCOUNTED FOR SYMPTOMS

If after diagnosing a client with a disorder, symptoms remain that are not accounted for in this diagnosis, consider a second diagnosis.

BOX 2.19 PRINCIPLE 9: CONTRIBUTING FACTORS

Remain mindful of potential medical conditions that may be responsible for your client's symptoms.

BOX 2.20 PRINCIPLE 10: CLIENT RESONANCE

This principle reminds us that our clients are our own best resource for understanding the quality of symptoms.

This principle forwards the idea that our clients are a key resource in arriving at an appropriate diagnosis.

Consultation. Remember the adage *pride goeth before the fall.* Don't allow a busy schedule or personal pressures to have mastered diagnosis to prevent you from asking for a consultation with a trusted colleague when you are left feeling less than confident with a diagnosis. Where possible establish an ongoing relationship with a trusted and seasoned professional with whom you can consult regularly. Talk through your diagnostic decision-making processes being sure to make note of your colleague's ideas, and to document questions that may have arisen thanks to your consultation. Include these notes with your case notes in order to document your effort to provide excellent care. Diagnosis is a complicated process and is all too often riddled with ambiguities; however, the stakes for your clients are high. The extra time you give to consultation with another thoughtful practitioner will pay dividends in increased accuracy and peace of mind.

Creating a symptom timeline. While clients may find it difficult to recall clearly when symptoms first began, you may find a symptom timeline to be supportive in your diagnostic process. Morrison (2007) suggests a symptom timeline can be drawn from a well-designed client intake form, provided this form outlines symptoms and provides an opportunity to describe when the symptom emerged as well as its duration, and provided the client is a good historian for their own symptoms. A symptom timeline can provide invaluable information in differentiating a diagnosis or determining if dual diagnoses is more appropriate. For example, a client, Jared, has been seeing his counselor for major depression for about a month. He reports that he is unable to sleep and would like to look into medication for this concern. Jared's counselor would like to do a symptom timeline and explore whether the sleep disturbance has been present at any time outside of his current depression or during the depression Jared experienced 5 years ago. His counselor believes this will help her to understand better if the sleep disturbance is a manifestation of depression or if it represents an independent difficulty.

Creating a diagnostic genogram. A number of disorders have a tendency to run in families, either because they have a genetic component, as with autism, or because they are learned through family systems. Sometimes both dynamics are at play. Morrison (2007) recommends creating a genogram of documented diagnoses. This process may help you to get a sense for the psychological environment in which your client grew up or currently lives within.

However, drawing conclusions about your client's diagnosis based on the diagnoses of family members is not appropriate. First, you will not be able to count on the accuracy or completeness of the diagnoses that are reported to you and placed in the genogram. Any reporting of undiagnosed mental health concerns will be highly biased and not fully informed. Remember, too, that a number of diagnostic terms are used in common parlance but may not represent an accurate reflection of diagnostic criteria. For instance, a client may report, "My mother is totally OCD, she freaks out if I miss my curfew or I forget to do my chores. It is so annoying." In this case, it is less likely

that the client's mother meets criteria for OCD and more likely that she is a bigger stickler for the rules than the client appreciates. Second, using the genogram to diagnose your client is at best a significant use of inference; used in addition to careful diagnostic processes; however, the genogram can provide supportive evidence when working with a cloudy diagnostic picture. A genogram is also useful in understanding better your client's perceptions and understanding of their own psychological environment and may potentially reveal family patterns for particular mental health concerns. Should you decide to make use of this tool, be sure to include physical disorders as well, since physical health has a significant impact on mental health and vice versa.

Conclusion

In this chapter, we have looked carefully at eight steps for arriving at a diagnosis. We have discussed the importance of carefully organizing presenting problems, symptoms and clinician observations and considering their relationship to one another. We looked at the structure of the formal diagnostic notation. We also explored 10 guiding principles for use in the diagnostic process. Finally, we explored the importance of cultivating relationships with other diagnosticians with whom you can confer about your conclusions and share questions. In Chapter 3 we will explore in depth the function and structure of the justification process, which constitutes the steps six and seven of the diagnostic process.

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