Reading Reflection, Critical Analysis, and Synthesis Paper

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Abstract

As clinicians, our primary focus is on effectively assisting our clients. That sounds simple enough, but it is not. In fact, it is complicated at first. There are many resources and organizations providing content on assessments, diagnoses, and effective treatments. The clinician is responsible for using empirically supported documents and resources, thus ensuring he or she is effectively assisting the client. This paper will discuss those documents and diagnoses in detail. First, starting with the comparison of the DSM-5 to the DSM-5-TR changes. It will also discuss the DSM-5-TR online assessment measures and differential diagnosis. This paper will discuss specific disorders from three chapters in two texts and the treatments for those disorders. Finally, this paper will discuss the assessment, diagnosis, and treatment plan for unspecified anxiety disorder.

Keywords: DSM-5-TR, Online Assessment Measures, Diagnosis, Treatment Plan

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The building of a strong foundation behind a therapist's diagnosis, case conceptualization, and treatment plan is having an empirically assessed and verified set of standard classifications to use as a diagnostic aid. This diagnostic aid is used to compare the client's presenting symptoms, identify the diagnosis and co-occurring diagnosis, and identify diagnostic rule-outs. One of the significant standards is the Diagnostic and Statistical Manual of Mental Disorders Revision 5, Text Revision (DSM-5-TR). Other important tools are client interviewing tools and assessments. While the process may seem simple, there are many factors to consider in diagnosis and treatment. Below begins this exploration of information by examining the changes that have occurred from the DSM-5 to the DSM-5-TR.

DSM-5 to DSM-5-TR

The DSM-5 was first published in 2013, 10 years ago. Since then, there has been a culmination of changes now reflected in the DSM-5-TR. The DSM-5-TR is the first text revision to the DSM-5. The DSM-5-TR is a result of three different revision efforts overseen by three organizations: the DSM-5 task force, the DSM Steering Committee, and the Revision Subcommittee. These groups' efforts corresponded to the other and were empirically evaluated and proven to have repeatable results.

A significant amount of the DSM-5 was changed over nine years. Changes from the DSM-5 to the DSM-5-TR consist of text updates such as changes to the diagnostic criteria, the addition of diagnostic entities, and the addition of ethno-racial equity factors (American Psychiatric Association, 2022). The ethno-racial equity addition to the DSM-5 allows for societal inclusion and changes in the past nine years. It also allows for changes in language within the DSM-5 that will prevent stigmatization (American Psychiatric Association, 2022). The above

changes to the DSM-5 to the DSM-TR allow clinicians and educators to provide the most recent, empirically proven diagnostic information regarding each mental disorder, diagnostic criteria, and socioeconomic factors due to social changes since the publication of the DSM-5.

DSM-5-TR Online Measures and Differential Diagnosis

When clients seek therapeutic services, they experience multiple symptoms that could indicate multiple disorders including co-occurring or comorbid disorders. There are multiple considerations in ensuring an accurate diagnosis. Elimination and consideration of fictitious information provided by the client, medical health factors, and alcohol or substance use as contributors to the client's presenting issues are primary (First, 2014). The American Psychological Association provides many resources for assisting the clinician with diagnosis. Some of these are assessments are clinician administered, and others are self-report assessments the client completes. The DSM-5-TR, the DSM-5 Handbook of Differential Diagnosis, and the DSM-5-TR Online Assessment Measures are just a few resources.

As a clinician, when working with new adult clients, it is wise to start with a Level 1 Cross-Cutting Symptom Measures questionnaire. A Level 1 Cross-Cutting Symptom Measures questionnaire can be completed by the client or by the informant representing the individual. This questionnaire consists of 23 questions that query the client regarding his or her emotions, level and quality of sleep, physiological symptoms, and behavioral patterns within the past two weeks (American Psychiatric Association, 2013). The questionnaire is scored on a scale of 0-4 (0 being the lowest and four being the most severe) (American Psychiatric Association, 2013). Suppose the rating scores are mild to severe for depression, anger, anxiety, mania, sleep problems, somatic symptoms, substance use, and repetitive thoughts. The clinician will follow up by administering a Level 2 questionnaire for each category if the client's scores indicate mild or

severe ratings in specific categories (American Psychiatric Association, 2013). Access to these resources for practicing counselors and educators is more than beneficial. It is a significant asset to this community, ensuring the diagnoses and rule-outs derived are accurate and measured by repetitive practices and measures.

Chapters and Articles

Trauma- and Stressor-Related Disorders

The three disorders I chose to research in the text are trauma- and stressor-related disorders, schizophrenia spectrum and other psychotic disorders, and dissociative disorders. Trauma- and stressor-related disorders include the following disorders: posttraumatic stress disorder (PTSD), reactive attachment disorder (RAD), acute stress disorders, adjustment disorders, and disinhibited social engagement disorder (DSED) (Dailey, 2014). I chose to research the trauma category because many of my clients are affected by life events detailed in this chapter, such as sexual abuse, assault, and/or witnesses to events that have happened to their siblings or parents. Some of these clients have experienced severe neglect by their caregivers, guardians, or parents.

One of the new pieces of information I learned from this chapter is the addition of DSED. DSED and RAD are similar in characteristics as they directly result from severe neglect by the caretaker (Dailey, 2014). However, children diagnosed with DSED reflect a lack of inhibition when approaching unknown individuals in social settings. These children freely wander away from their caregivers without regard. Often, these individuals live in institutions such as orphanages or are raised in environments where societal norms are not standard (Dailey, 2014). The cause of RAD is the same as DSED, severe neglect, but the symptoms are distinctively different. Individuals diagnosed with RAD have trouble conforming to social norms and

appropriate behaviors (Dailey, 2014). They avoid efforts towards being comforted by others. They avoid social interactions. They also shy away from participating appropriately in social settings. For example, a child may choose to withhold acceptable social interaction or behavior at will rather than involuntarily. The RAD diagnosis is employed when a child has had necessities withheld and cannot form the appropriate attachments for his or her specific age level. Using RAD as a diagnosis is rare (Dailey, 2014).

RAD and DSED can be assessed using The Child and Adolescent Psychiatric Assessment-RAD (Lehmann, 2020). This assessment is a component of a more extensive assessment. It contains three questions that are RAD focused and three questions that are DSED-focused. This assessment is based on the DSM-IV criteria and exhibits consistency and reliability (Lehmann, 2020).

PTSD differs from RAD and DSED in that it is believed not to be created by neglect but solely by traumatic events witnessed or experienced. Thus, neglect is not part of PTSD's diagnostic criteria (Dailey, 2014). Unlike PTSD, the behaviors displayed in the diagnosis of RAD are controlled by the participant. PTSD behaviors are subconscious and involuntary when a thought, current event, or stimulus triggers memories of past trauma. The individual uses avoidance to alleviate stress due to stimuli (Dailey, 2014).

The interview assessment for PTSD assesses Criterion A and the frequency of symptoms (Antony, 2020). The preferred assessment model for individuals with PTSD is assessment through the individual's primary care physician (Antony, 2020). This is because individuals who have experienced trauma have a higher probability of additional health issues, and the primary care physician is the first to interact with these individuals (Antony, 2020). However, assessment is not conducted in the primary healthcare arena (Antony, 2020). The clinicians in the healthcare

setting are uncomfortable facilitating PTSD assessment due to a lack of training and the sensitivity of the questioning for these disorders (Antony, 2020). In a therapeutic setting, assessment is started by administering either the CAPS-5 (clinician-administered) interview or the PCL-5 (self-administered) assessment (Antony, 2020). The nature of questioning for PTSD assessments can be uncomfortable for the client to discuss openly with the clinician. As such, using the self-administered assessment is advantageous for both the client and the clinician. Self-administered assessments yield more information than clinician-administered interviews (Antony, 2020). The clinician may also assess the client using the National Stressful Events Survey PTSD Short Scale (NSESSS), a self-administered assessment. The NSESSS is a nine-question assessment tool scored on a rating scale of zero to four (zero, lowest to four highest), with the highest score denoting the highest severity (Kilpatrick, 2013). Clinicians consider the individual score for each category on the assessment. Then the clinician examines the average total assessment score to result in a single number and indicates the severity or lack thereof. This assessment can be administered initially to identify the presence and severity of PTSD and to track the changes in the severity of PTSD (Kilpatrick, 2013).

Schizophrenia Spectrum and Other Psychotic Disorders

Schizophrenia spectrum and other psychotic disorders were chosen to give me a more secure foundation to work with my clients and their parents. Working with these types of clients and being able to diagnose them properly is something I am not yet comfortable with spiritually or professionally. All the disorders in this category are characterized by deviations of one or more of the following: delusions, hallucinations, disjointed thought processes, disoriented or lack of motor control, and other damaging symptoms (2014). One of the most critical considerations when diagnosing a client with these disorders is to rule out any substance use or

medical factors contributing to the client's symptoms. One interesting piece of information about these disorders is that one symptom can be considered in other diagnoses. For example, delusions are included in the diagnosis of OCD, BDD, and other depressive disorders (2014). When a symptom applies to multiple disorders, the clinician must research those disorders to determine if it is a better fit for the client or a rule out.

Three disorders within this category overlap in symptoms: schizophreniform disorder, schizophrenia, and schizoaffective disorder. Schizophreniform disorder is a preface to full-blown schizophrenia. Schizophreniform is considered more than a brief psychotic disorder and less than schizophrenia. It is characterized by experiencing two or more of the symptoms listed above, lasting between one to six months (2014). Sixty-seven percent of individuals diagnosed with schizophreniform go on to develop schizophrenia (American Psychiatric Association, 2022).

Schizophrenia's symptoms include at least two of the symptoms listed above, and the presence of hallucinations, delusions, and muddled speech is mandatory for the diagnosis. The individual must have experienced these symptoms for six months or longer (2014). Though schizophrenia affects a low percentage of the population worldwide, most individuals diagnosed with schizophrenia will have it or symptom difficulty for a lifetime (2014). Schizophrenia is considered the foremost diagnosis contributing to health-related costs in the world (Devylder, 2016). These costs are a culmination of health care, pharmacology, criminal justice, and family impact cost and equate to $60 billion yearly (Devylder, 2016). In the United States, 50,000 individuals are diagnosed with schizophrenia yearly (Devylder, 2016). However, as with other disorders, clinicians must consider substance use, existing physiological illnesses, and co-occurring mental disorders in the assessment and diagnosis process. Mood disorders, substance

use, and medical conditions are more prevalent with schizophrenia and should be factored into the assessments and treatment plans for the disorder (Antony, 2020).

Schizoaffective disorder consists of Criterion A of schizophrenia disorder coupled with mood, either manic or depressive (2014). The mood portion of the diagnosis is present during most of the conditions (2014). Due to this disorder having both schizophrenia and mood disorder traits, treatments for both types of disorders are effective for schizoaffective disorder (2014). These disorders are considered unreliable and inconsistent in their behaviors (2014). One of the assessment tools to diagnose Schizophrenia spectrum disorders and other psychotic disorders is The Social Behavior Schedule (SBS) assessment (Antony, 2020). This test is administered by the clinician and the client, and someone closely related to them completes the interview (Antony, 2020). This assessment covers a broad array of the client's interactive functioning, including work, familial, and social interactions, communication, and performance (Antony, 2020).

Dissociative Disorders

There are two distinct types of dissociative states: normal and abnormal. Normal dissociative states include daydreaming, becoming immersed in a movie, book, or activity, and entrancing while driving (Richardson, 1998). Negative dissociative states are more severe as they cause disturbances in the functioning or identity of the individual (Richardson, 1998). Dissociative disorders reflect a disconnection either, personalization, memory, and identity change or confusion. There are three different dissociate disorders: dissociative identity disorder, dissociative amnesia, and depersonalization/derealization disorder (Dailey, 2014). Derealization is a detachment from reality, and depersonalization is a detachment from the self. The difference between detachment from self and dissociative identity is that depersonalization

is as if separating from one's body rather than separation from one's identity. Dissociative disorders are believed to have their onset because of a traumatic event (Dailey, 2014).

Both structured and semi-structured interviews can be utilized for client assessment for symptoms of dissociative disorders (Antony, 2020). Structured assessments are interview questionnaires with specific, static questioning verbiage, the number of questions, and the type of questions with no change allowance (Antony, 2020). Semi-structured has more fluidity and flexibility in its questioning, allowing the clinician more freedom for changes (Antony, 2020). Self-reporting questionnaires are more of a standard process in individual practices allowing the client to complete the questionnaire detailing their symptoms and severity (Antony, 2020). The Dissociative Experience Scale (DES) is used to assess the presence of dissociative disorders (Antony, 2020). The DES assessment is only an indicator of traits and does not assess the disorder (Antony, 2020).

Outline of Treatment

The condition I chose to assess and treat is F41.9 unspecified anxiety disorder. The client is a 25-year-old Caucasian female, named Molly Wilder. Her first session was an intake session on March 4, 2023. The client completed and signed all consent to treatment and confidentiality forms during this session. Next, as the clinician, I interviewed the client using the organization's biopsychosocial document.

Biopsychosocial

The biopsychosocial document consists of four pages and is mandatory to use as instructed by the company I support. The biopsychosocial assists me, as the clinician, in interviewing the client to understand the client's therapeutic and medical needs fully. I start by asking the client, Molly, why she has come to therapy. Then ask her to explain her problem(s)

and associated symptoms. Once Molly identifies her problems, symptoms and desires I ask her how long she has been experiencing these issues and whether she has participated in mental health treatment before our meeting. During the interviewing process, I monitor the client's speech to determine whether it is coherent and understandable. I also examine the degree of eye contact Molly provides. I assess Molly's orientation to gain an understanding of whether she is alert to person, time, place, and current events. I also evaluate Molly's mood and affect. Are they congruent or incongruent with her behavior? All this information is needed for me to document Molly's mental status exam information.

The next section of the biopsychosocial document asks questions regarding the client's developmental history, including the client's developmental milestones, vision, language issues, and hearing. After the developmental history, I query Molly about her family history. This section is not to understand the client's genealogy but to understand the client's familial support system. Only supporting persons are added in this section. Another significant section of the biopsychosocial questionnaire focuses on the client's social and spiritual activities and beliefs. What does Molly do for fun? Is she part of any social groups or activities in the community, or is she a person that shies away from social gatherings? Does Molly have a religion or practice any spirituality?

One of the remaining categories on the biopsychosocial questionnaire seeks information about the client's legal history. Does the client have any open, active legal issues? Are there any current or historical DCF cases? If so, when did they start, and what was their nature? Substance use information for the client and the client's family is also requested. If yes, this must be adequately considered when establishing a diagnosis. The client's mental and health history is also requested, as is that of her family. Lastly, the client is asked whether she is currently on any

medications, the dosage, and the frequency of use. Gathering all this information allows me to develop a problem statement, observe the client's social interaction and communication abilities, and assess the client's exposure to trauma.

After completing the biopsychosocial with the client, I would request the client complete a Level 1 Cross-Cutting Symptoms Measures for adults (American Psychiatric Association, 2013). This can also be administered when the client checks in for their appointment to allow me to review the rating as the client provides additional information in the biopsychosocial section of the session. If the rating scores in the Level 1 assessment are mild or greater in the anxiety category, the next step is administering the level two Anxiety-Adult (PROMIS Emotional Distress-Anxiety-Short Form) (American Psychiatric Association, 2013). The Level 2 questionnaire focuses solely on anxiety and is composed of seven questions with a scale of 1-5, with one being the least and five being the greatest. If the client scores higher than 55, then there is a mild presence of anxiety. A score of 60 indicates moderate anxiety, and a score of 70 and over indicates severe anxiety (American Psychiatric Association, 2013). This questionnaire can be used to assess improvement during the treatment process. Though assessment is an essential part of case conceptualization, the information gathered through the biopsychosocial questionnaire coupled with the Level 1 and Level 2 assessments will give me a stronger basis for anxiety as a diagnosis and establish an effective treatment plan.

My preference regarding assessments is to conduct the clinical intake and gather the assessment data in the first session. Then provide information regarding results and diagnosis on the second or third visit. This allows me more time to understand the diagnosis and then develop the treatment plan fully. However, my organization's policy is to have all documentation

complete and signed within two days of seeing the client due to insurance company policies. This is especially true when taking clients that have Medicaid coverage.

Depending on the client's preference and the severity of the client's anxiety levels, pharmacology can be included in the treatment plan for the client. Though I cannot prescribe medications as the counselor, I can refer the client back to their doctor or the organization's on-staff psychiatrist for medication evaluation. In addition to pharmacology, psychotherapy is also effective in treating anxiety. Cognitive Behavioral Therapy (CBT) is a proven-acceptable technique for treating anxiety (Beck, 1976). CBT consists of many practical tools. Psychoeducation teaches the client about anxiety, and the physiological events that occur when experiencing anxiety. It teaches the client the benefit of controlling and restructuring thoughts. Through psychoeducation, I begin to collaborate with the client to understand her triggers to anxiety and then employ techniques such as mindfulness exercises to counteract and manage anxiety levels. Mindfulness exercises ground the client in the current moment and allows the client to focus on the here and now instead of what has occurred in the past or what could occur in the future.

Along with establishing the techniques and modalities to be used in treatment, identifying the assessment tools to measure improvement is essential. It is also important to denote when treatment ends. In the case of this diagnosis, when Molly's anxiety rating is 55 or below, she can maintain that rating for a significant period, for example, six weeks consecutively. Molly will have then completed therapy. The completion will be evidenced by administering the Level 2 test referenced above.

Conclusion

There have been many changes in the DSM-5 to the DSM-5-TR. All these changes have improved and enhanced the care given to clients through assessments to diagnosis. The American Psychological Association is an integral player in providing valid and repeatable changes to the DSM based on societal shifts and empirical research and testing. Though the APA's publication of documentation and assessment scales seems limitless, these tools are essential to making sure the therapeutic profession stays abreast of societal needs and best practices. While a clinician is to be aware of his or her internal business processes and procedures regarding clients, it is equally important to know what professionally supported tools are used in addition to what is provided within your company, especially if they are different documents than what your company chooses.

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