Reading, Reflection, Critical Analysis and Synthesis Paper

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Abstract

The Mental Health field no longer recommends brief familiarity with the DSM-5 manual, but rather a diligent and determined effort to thoroughly understand the content and apply it with competence and confidence. This paper provides an overview of the history of the DSM, major structural and philosophical changes including the removal of a multiaxial system and the Global Assessment of Functioning (GAF), and the shift from using roman numerals to Arabic numbers. A closer look into different diagnoses that I wanted to learn more about such as: Depressive, Anxiety, Trauma and Stressor-related, Substance – related, and Dissociative Disorders are discussed in further detail, and corresponding evidence based treatments and pharmacological treatments are discussed. An alternative personality model is discussed and a strong emphasis placed on cultural assessment hence providing a cultural formulation interview.

Keywords: clinical utility, structural and philosophical changes, accurate diagnosis

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Current research is proving that counselors are required to demonstrate efficacy in their field. While all good counselors are making every effort to provide effective counseling, third party payers are mandating accountability. Counselors are hopefully gaining a clarifying view of the importance of understanding the DSM-5 to improve clinical utility. The goal of this paper is to emphasize the major changes that have occurred throughout the history of the DSM manual and to learn about a variety of disorders that are of personal interest and their related evidence based treatment. There are implications for counselors to participate in active roles of the revision process and advocacy as the DSM continues to evolve and the field of Mental Health, however we must represent ourselves well and provide accurate diagnosis, and effective treatment.

Reflections from Dailey et. al. Chapter One

In this chapter Dailey et.al. (2014), addresses the importance of counselors being extremely familiar with the DSM – 5, and apprised of the changes from the DSM-IV –TR. The DSM – 5 serves as the universal language for all Mental Health Practitioners. It is a resource that helps to clarify a client's presenting problems and provide the framework to make accurate diagnoses. Third-party payments are mandating diagnostic assessments using the DSM-5, therefore it is integral that counselors have a thorough understanding of the manual. Professional counselors have often been hesitant in using the DSM-5 due to lack of familiarity and confidence with regards to making a diagnosis; however ACA encourages counselors to learn the DSM-5 and collaborate with other Mental Health providers.

The revision process for the DSM-5 was complex and interesting to learn about. The groundwork began in 1999 with the initial conference held to determine what the priorities and

new focus of the DSM-V would be. Six work groups were formed to focus on a variety of areas: nomenclature, neuroscience and genetics, developmental issues, personality and relational disorder, mental disorders and disability, and cross-cultural issues. Several conferences were held between 2004 and 2008 to receive feedback from fellow colleagues and other professionals, about changes needed and discuss relevant diagnostic information.

The APA led the way in this research task, and although no professional counselors participated in the task force, the ACA ensured that they contributed. Two ACA presidents wrote letters sharing their concerns about the revisions made, and it was highlighted that the professional counselors were among the second largest group to utilize the DSM-V.

I enjoyed reading the history of the DSM and its evolution thus far. I've learned a lot about how the manual came into being and all efforts being made to keep mental health professionals apprised of new insights is most admirable.

Reflections from Dailey et. al. Chapter Two

Chapter two focuses on the history of the DSM as well as major structural, philosophical, & diagnostic changes of the DSM-V. In 1952 when the DSM-I was published, it was largely influenced by Adolf Meyers, a leading psychiatrist at that time who suggested that mental health issues were a result of reactions of an individual's personality to biopsychosocial situations. The DSM-I had three categories: organic brain syndromes, functional disorders and mental deficiency, and narrative descriptions with only one diagnosis applicable to children: adjustment reaction of childhood/adolescence.

By the time the DSM- II was published, there were eleven categories and nearly 182 disorders. This was published in 1962, with plans already underway for the DSM-III. This latest edition demonstrated a significant shift from heavy reliance on clinicians' subjective opinions to

a specific set of diagnostic criteria. Perhaps the most significant shift for the DSM –III was the introduction of the multiaxial system and inclusion of features such as gender, cultural, demographics and familial patterns were included. The DSM-III became widely used by many practitioners who sought a more holistic approach for their clients and access to psychometrically sound assessments.

Once again, critiques resulted in conservative changes for the DSM IV, and DSM-IV-TR. Although the intent was toward mild changes, a noticeable revision was to separate people from their diagnoses (e.g, a person with schizophrenia as opposed to a schizophrenic). There was much debate from professionals who felt it was still a strong medical model. Counselors who tend to view their clients as a whole-person with a strength-focused approach, desire to achieve wellness and not simply to reduce symptoms thus realizing that their diagnosis is just one part of the client's entire picture.

The most recent edition of the DSM-5 made structural and philosophical changes. Previous editions had one general section, however currently there are three sections. Section I gives information about all of the revisions, and additional information about using the manual. The second section addresses all diagnoses into separate chapters but still ordered by similarity allowing practitioners to better differentiate between disorders that share symptom characteristics. The DSM-5 expanded on previous cultural features with section III giving attention to diversity among different cultural groups – a Cultural Formulation Interview is also provided to assist practitioners in gathering accurate data.

Structural change also included the elimination of the Multiaxial system and the Global Assessment of Functioning (GAF) notes, and inclusion of both codes ICD-9-CM and ICD-10-CM.

Reflections from Dailey et al. Chapter 3 and Gabbard Chapter 14

The Depressive disorders are some of the leading issues in counseling currently. I selected this chapter to learn more about depression, because the term is misused frequently, and it is genuinely such a sad condition to have. Depressive disorders are characterized by extended emotional dejection, sadness and withdrawal. It is a persistent state that interrupts daily functioning.

Major changes from the DSM-IV-TR to DSM-5 include a distinction between depressive disorders and bipolar, the inclusion of disruptive mood dysregulation disorder and premenstrual dysphoric disorder. The disruptive mood dysregulation disorder (DMDD) provides an adequate diagnosis for adolescents between the ages of 6-18 who didn't truly fit the diagnostic criteria for conflict and bipolar disorder. Features of DMDD include severe recurrent outbursts of temper that are out of proportion to the situation and developmental state of the individual. These behaviors must occur in at least two settings, three times per week for at least 12 months or more. Premenstrual Dysphoric Disorder (PMDD) previously identified as not otherwise specified (NOS), is not listed as a disorder. It is characterized by intense emotional and physical symptoms that occur during menstruation such as: suddenly feeling sad, or tearful, severe mood swings, feelings of hopelessness, self-critical thoughts and noticeable anxiety and edginess.

Several factors contribute to the root causes of depressive disorders: environment, personality, biological, neurochemistry and developmental processes. It can be successfully treated at early diagnosis. Evidence-based treatment outcomes indicate that Cognitive Behavioral Therapy and Interpersonal therapy are the most efficacious.

Depressive disorders are more prevalent in women and commonly diagnosed in African Americans and Latinos. Most times these individuals tend to be unemployed, previously married

and without health insurance. If there is a family history of depressive disorders, the risk is higher for an individual to develop depression.

Effective pharmacological and somatic treatments for Major Depressive Disorder include Monoaminergic antidepressants and evidence based psychotherapy (Gabbard, 2014). Historically, there have been first and second generation antidepressants to treat depression. The first generation are Tricyclic and related antidepressants, and Monoamine Oxidase Inhibitors. The second generation antidepressants include Selective Serotonin Reuptake Inhibitors (SSRI's). These medications do not appear to be more effective than first generation, however they have milder side effect profiles and tend to work better in more severely ill patients.

Reflections from Dailey et. al. Chapter 5 & Gabbard Chapter 16

Anxiety Disorders are highly prevalent among the general population and is found more common in females than males. It is characterized by the anticipation of future threat and differs from fear which is considered an emotional response to real or perceived imminent threat. Most individuals who are diagnosed with anxiety often times also meet the criteria for depressive disorders (Dailey et.al. 2014).

There are several psychobiological factors that contribute to the etiology of anxiety: genetic predisposition, social and cultural contexts and life events (Daily et. al. 2014).

Major changes from the DSM-IV-TR to DSM-5 include a distinct separation between anxiety disorders, obsessive-compulsive and related disorders, and trauma and stressor-related disorders. All anxiety disorders such as separation anxiety, selective mutism, specific phobia, social anxiety disorder, panic disorder, agoraphobia, generalized anxiety and substance medication induced anxiety disorder are clustered together. This allows practitioners to readily

identify similar symptoms however accurately differentiate between closely resembling diagnoses.

Separation Anxiety Disorder (SAD) was previously only diagnosed in childhood, but can now be diagnosed in adults. It is observed that many adults with other anxiety disorders appear to have had a history of childhood SAD. This disorder has features that include: fear of being alone without an attachment figure, avoidance of sleeping in the bed alone, repeated nightmares about separating, and physical symptoms such as headaches, stomachaches, nausea, vomiting or panic-like symptoms. CBT has been the most effective treatment for SAD; helping children to identify feelings of anxiety, modify self-talk, and devise coping plans (Gabbard, 2014).

Social Anxiety Disorders also knows as Social Phobia is marked by an intense fear or anxiety about one or more social situations in which an individual is exposed to possible scrutiny by others. The thought of any social situation almost always induces fear or anxiety. These features must be present for a period of six months or more. CBT has been noted as the most efficient treatment for Social Phobia, along with mindfulness and acceptance-based therapies (Gabbard, 2014).

Generalized Anxiety Disorder (GAD) is perhaps the most distressing disorder. It causes significant interruptions in daily areas of function comparable to Major Depressive Disorders. Generally speaking, GAD has a later onset than other anxiety disorders and is marked by excessive anxiety and worry, occurring more days than not for at least six months. Effective therapeutic treatments include CBT, Interpersonal and emotional therapies, and pharmacological treatments include SSRI's (Gabbard, 2014).

Specific Phobia is characterized by fear or anxiety about a specific object or situation. Usually there are four subtypes that induce fear: 1. Animals, 2. Natural environments, 3. Blood

injection injury, and 4. Situational. This anxiety disorders responds well to gradual exposure therapy, which involves firstly educating the client about their phobic response, secondly allowing clients to create a fear hierarchy with ranked items, and thirdly the therapist and client work together on exposure to less feared items where the client remains in contact with the object long enough for the anxiety to decrease.

Individuals diagnosed with anxiety tend to have a high risk of suicide hence it is recommended that counselors consistently use a suicide risk assessment throughout the therapeutic treatment (Dailey et. al. 2014).

The most effective psychological treatment for anxiety disorders is Cognitive Behavioral Therapy, with a focus on psychoeducation, cognitive restructuring, and exposure and relapse prevention. Pharmacological treatments include Tricyclic Antidepressants, and Selective Serotonin Reuptake Inhibitors (SSRI's).

Reflections from Dailey et. al. Chapter 7 and Gabbard Chapter 27 & 28

Trauma refers to an individual's emotional response to a severe event such as combat, sexual assault, severe accident, abuse or exposure to a natural or human-caused disaster. These events significantly disrupt a person's ability to cope and manage their daily lives. Stressor-related events are less severe and exist for a shorter period of time (e.g. relationship break-ups, business difficulties or loss of a job or marital issues).

The most noticeable change from the DSM-IV-TR to DSM-5 is a new chapter which includes: Post Traumatic Stress Disorder (PTSD), Acute stress disorder, Adjustment Disorders, Reactive Attachment Disorder (RAD), and a new category – Disinhibited Social Engagement Disorder (DSED). Both PTSD and Acute stress disorder were previously categorized as anxiety

disorders, however these disorders are now placed together due to shared foundations in external events (Dailey et.al. 2014).

RAD is characterized by developmentally inappropriate social relatedness in children before the age of five. It appears to occur due to an extreme inadequate environment where care-giving has never occurred. These children have never had the opportunity to develop stable attachments and experienced extreme disregard for their physical and emotional needs. Cultural norms must be taken into consideration before making a diagnosis of RAD (Daily et.al. 2014).

PTSD can only be diagnosed if an individual has been exposed to one or more traumatic or stressful events or circumstances. Symptoms of PTSD can include daytime memories of the event, images or flashbacks, disconnect from others and overall loss of sense of purpose in life or the future. PTSD was previously grouped as an anxiety disorder, but with a criteria change from the DSM-IV-TR to DSM-5 which pays closer attention to what is considered a traumatic event resulting in a new chapter.

One of the new criteria is the recurring or intense frequent exposure to extreme traumas commonly seen by law enforcers and first responders. For an accurate diagnosis practitioners must ensure that individuals meet the criteria and not just exposure to a traumatic event. Additional criteria includes: intrusion, avoidance, negative alteration in cognitions and mood, and alterations in arousal and reactivity (Dailey et.al. 2014)

Due to recent catastrophic events of Hurricane Dorian in Grand Bahama, Bahamas, I had a strong interest in reading and understanding more about Trauma and Stressor-related disorders.

Acute Stress Disorder (ASD) was first introduced in the DSM-IV and can occur with individuals who are experiencing acute stress responses as a result of exposure to a traumatic

event. ASD differs from PTSD in two ways; symptoms last more than three days but less than one month, and ASD does not require an individual to have symptom clusters.

Adjustment Disorder refers to individuals who do not meet the criteria for PTSD or ASD but are experiencing significant distress due to a particular source of stress. Examples of these stressors could include: major life changes (retirement, or going back to school, loss of something, or ending of a relationship). It is important to note that the stressor for an accurate diagnosis of adjustment disorder is not a traumatic event. Individuals tend to have impaired relationships in their personal life or work life and oftentimes their stress symptoms exceed what would be expected due to the nature of the stressor.

Most effective psychotherapeutic and pharmacological treatment for PTSD is Trauma-focused CBT, and antidepressants (Gabbard, 2014). With over 300 ongoing trials, PTSD is gaining a lot of research which leads to substantial amounts of literature that practitioners need to be aware of. Trauma-focused CBT techniques focus on having the patient face the trauma and not avoid it. It also encourages the patients to face distorted cognitions related to the trauma that allow the symptoms of PTSD to persist.

A different therapeutic treatment is exposure therapy which seeks to reduce the fear by repeatedly exposing the patient to that memory and reminder. When a patient is able to face the memory, they can begin to emotionally process what has happened and begin to rectify distorted trauma cognitions. This form of psychotherapy is considered the gold standard of treatment for PTSD (Gabbard, 2014).

Cognitive Processing Therapy focuses on changing detrimental thoughts related to the trauma as opposed to reducing fear. There are three main focuses: 1. Psychoeducation and identification of stuck points, 2. Narrative, written exposures designed to have patients begin to

challenge these beliefs, and 3. Further challenge and reshape stuck points into healthier thought patterns (Gabbard, 2014).

Eye Movement Desensitization and Reprocessing treatment is an eight-phase process that combines trauma-focused exposure and cognitive therapy with bilateral stimulation. Despite the critiques of EMDR, research still shows that EMDR is effective and PTSD (Gabbard, 2014).

When patients are not responding to psychotherapeutic interventions, medication becomes an option. General recommendations for first-line medical treatment includes: Selective Serotonin Reuptake Inhibitors (SSRI's), and Serotonin-norepinephrine reuptake inhibitor (SNRI) venlaxafine. An additional option for treatment is Medication-Enhanced Psychotherapy (MEP) which refers to SSRI's added to psychotherapeutic treatment's most commonly Prolonged Exposure Therapy (PE) (Gabbard, 2014).

PTSD is an unfortunate diagnosis for individuals, however research highly supports that effective treatments exist which provides great hope and outcome for individuals to be successful.

Reflections from Dailey et.al. Chapter 9 and Gabbard Chapter 46-62

Substance-related disorders initially didn't garner my attention, however as I read through the chapter and saw how prevalent it is globally and perhaps even more than I realized in The Bahamas, I decided it would be both helpful and necessary to understand it better.

Addiction is described as a chronic disease of brain reward, motivation, memory and related circuitry (Dailey et.al. 2014). This circuit dysfunction contributes to a variety of issues on psychological and physiological wellness. There are ten classes of drugs (alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics and anxiolytics; stimulants; tobacco; and other/known substances) that activate the brain's reward system. Frequent use of

these substances often leads to severe impairment in several areas of daily functioning. While there are 11 components to criteria A, only two must be met to justify a clinical diagnosis.

Major changes from the DSM-IV-TR include the removal of distinction between abuse and dependence which was replaced with severity ratings. Severity ratings provide counselors the ability to tailor the treatment options depending on a mild, moderate or severe rating. Disorders within this group are now considered separate, and there are three classifications: use, intoxication, and withdrawal that are coded separately. Gambling disorder represents the first time that a process related addictive behavior was grouped along with substance. This decision has been based on research that shows that the symptoms of gambling disorder share similarities to substance use disorders.

Substance Intoxication occurs after substance use and psychological changes result from the physiological effects of the substance. Symptoms include alterations in thinking, judgement, perception, interpersonal behavior, psychomotor behavior and wakefulness. Substance Withdrawal refers to symptoms experienced as a result from stopping or reducing substance use. These symptoms include psychological and physiological effects and can be extremely unpleasant.

Gambling Disorder, a new edition to the DSM-5 is more prevalent in males and studies show a strong neurological basis with evidence of a higher prevalence in identical twins as oppose to fraternal. The behavior of gambling has been shown to activate the brain reward system (Dailey et.al. 2014). It is helpful that this disorder is now included in the DSM-5 as struggling individuals can receive treatment, however when treating the disorder clinicians must keep track of other potential diagnoses including: personality disorders, manic episodes, or other medical

conditions. There are limited evidence-based treatments for Gambling, but the strongest consideration is CBT (Gabbard, 2014).

Treatment of any Substance-related disorders requires several key elements. The client must understand that the use of the substance itself is a problem and be willing to make this a goal in counseling. Oftentimes these patients present other symptoms as the problem, depression, anxiety, or medical illness. The most effective approach to Alcohol – related disorder is Motivational Interviewing (MI). MI uses empathy, reflective listening, and an interpersonal framework to begin treating the disorder (Gabbard, 2014). Withdrawal symptoms including anxiety, irritability and insomnia can arise once an individual stops uses alcohol. The pharmacological treatment is benzodiazepines (Gabbard, 2014).

Familiar approaches to substance-related disorders tend to be behaviorally focused; e.g 12 step programs such as Alcoholics Anonymous (AA). However despite its widespread use, these are not empirically tested treatments. MI and CBT combined are described as being the most effective treatment. Antidipsotropic medications have proven to be effective at relapse prevention in abstinent patients or promoting reduction in alcohol use. These medications include Naltrexone, Acamprosate, and Disulfiram which are all FDA approved.

Sedative, Hypnotic, Anxiolytic – related disorders refer to the use of medications that induce sleep, sedation, a sense of calm, respiratory depression and a coma (Gabbard, 2014). Oftentimes, these disorders are largely diagnosed in elderly patients who tend to need a variety of medications with side effects and are often prescribed benzodiazepines (Gabbard, 2014).

For Opiods – related disorders, there is a preparatory treatment called opioid detoxification and the actual treatment which is the use of agonist maintenance therapy. Certain medications such as methadone and buprenorphine attach to the opioid receptors and stimulate them; hence

the craving and withdrawal symptoms are reduced. However, individuals can become dependent on them. This leads us to the preferred choice of treatment which are antagonist medications; these medications provide a safe and effective treatment and does not encourage physical dependence (Gabbard, 2014).

Cannabis – related disorder is commonly diagnosed and counselors need to feel extremely comfortable with evidence based treatments for this diagnosis. MI, CBT and Contingency Management Therapy are the leading treatments for Cannabis disorders, with Contingency Management being the preferred first-line of treatment (Gabbard, 2014). Contingency Management is actually based on a reward/voucher system and has proven to be most effective in promoting abstinence, but can be costly (Gabbard, 2014). Pharmacological Treatments are limited in efficacy, but the treatment considered most effective is N-acetylcysteine.

Most importantly among all of the treatment plans for Substance-Related Disorders thrive with a strong support system. Individuals struggling specifically in these areas need a lot of family support, support from their significant others. Involvement of family shows marked improvement in the participation of the individual and the overall psychosocial functioning of the entire family (Gabbard, 2014).

Reflections from Dailey et.al. Chapter 14 and Gabbard Chapter 24-26

Dissociative disorders can be described as a disconnection between things that are usually associated. Generally after a traumatic incident, the brain tries to protect itself during times of distress; there is a noticeable disruption in the regular integration of consciousness, memory, identity, emotion, and behavior (Dailey et.al. 2014). Dissociation usually represents an adaptive response to an inescapable threat or danger, where fight or flight is not possible (Gabbard, 2014). Counselors must pay close attention or notice symptoms of dissociation especially when trauma

or abuse is being probed or discussed, especially due to dissociation serving as a protective function.

There are five types of dissociation: depersonalization/derealization, amnesia, identity confusion, and identity alteration. Dissociative disorders are highly comorbid with other disorders and sadly is often missed in clinical settings as the symptoms may be caused by medical conditions, or triggered by substance abuse. Counselors should always refer clients for a medical evaluation and psychiatric consultation, when working with clients who experience dissociative symptoms.

Major changes from the DSM-IV-TR to DSM-5 include Dissociative disorders being placed directly after Trauma and Stressor-related disorders, and the renaming of depersonalization to depersonalization/derealization (Dailey et.al. 2014). Criterion B includes everyday gaps in memory as oppose to just relating to trauma and criterion A allows self-report or observation of dissociative symptoms (Dailey et.al. 2014).

Dissociative disorders largely appear to be linked to early experiences of traumatic events. There is no evidence of a genetic factor, but strong connections to environmental and biological components. Events such as physical, sexual or emotional abuse; chronic neglect; witnessing violence or loss of a loved one are just a few examples of experiences that can lead to the development of dissociative disorders (Dailey et. al. 2014).

Dissociative Identity Disorder (DID) can be characterized by usual gaps in everyday recall, two or more distinct personality states. Formerly called multiple personality disorder, this especially resonates with me because there are links to spiritual possession and within the Bahamian culture, spirituality and demon possession play a large role in how these symptoms are

understood. I enjoyed reading this chapter and particularly this section, because it provides an identification for such symptoms that provides clarification (Dailey et.al. 2014).

Dissociate Amnesia is characterized as forgetting second nature or autobiographical information. The amnesia may be localized, selective, generalized, systematized or continuous (Dailey et al. 2014). Gabbard (2014) suggests that it can be understood as an adaptive process where the patient is unable to tolerate the full conscious awareness of the information and emotion.

Depersonalization/Derealization is a disconnect with intact reality that results in distress or impairment and the experience is not substance or medically induced (Dailey et. al. 2014).

Treatment of Dissociative Disorders is recommended across five stages with a variety of components comprising the treatment. These components include: establishing safety, establish/repair alliance, teaching and practicing grounding, psychoeducation, teaching and practicing self-care, developing healthy relationships, affect tolerance and impulse control, stabilizing from current day stressors, and teaching/practicing containment (Gabbard, 2014).

Stage one and two focus on safety and stability, stage three and four focus on processing the trauma memories and the fifth stage is directed toward the client living well in the present. The entire treatment is geared toward the patient having a better adaptation in their current living situation. A top priority is developing and repairing the therapeutic alliance and providing safety. This component accounts for large portion of positive change. Psychotherapeutic treatments have been considered the most effective line of treatment, whereas pharmacological interventions are not particularly effective. At times, medication can even exacerbate memory problems.

Psychoeducation is vital in the first stage of treating Dissociate disorders. Helping the patient to organize a framework to understand his or her condition and the symptoms can be extremely powerful. Clinicians should use non-leading questions to encourage clients to tell their story while making every effort to remind the clients of their continued safety (Dailey et.al. 2014). The main goal of treatment is to safely guide the patient to explicate, work through, and restructure the patient's thoughts and feelings related to the antecedent trauma (Dailey, et.al. 2014).

Reflections from Dailey et al. Chapter 16

This Chapter on Personality Disorders seeks to present the ten distinct types of personality disorders with brief descriptions of each one and to draw attention that there are no major changes between the DSM-IV-TR and the DSM-5. Personality Disorders are deep-seated behaviors that can be very difficult or slow to change and are typically rigid and uncompromising. They tend to have an onset prior to early adulthood, and the patterns of internal and external behavior presentations are significant deviations from the individual's cultural expectations (Dailey et.al. 2014).

The ten distinct types of personality disorders are: 1. Paranoid, 2. Schizoid, 3. Schizotypal, 4. Antisocial, 5. Borderline, 6. Histrionic, 7. Narcissistic, 8. Avoidant, 9. Dependent, and 10. Obsessive – Compulsive (Dailey et.al. 2014). A few of these personality disorders really stood out to me and I would like to discuss them in further detail.

Antisocial Personality Disorder is described quite differently than the usual stereotypical view. It is characterized by a complete disregard for the feelings and rights of others and includes negative behaviors such as chronic lying, illegal activity, and aggression.

The most common disorder that is diagnosed is the Dependent Personality Disorder. This personality type is extremely dependent on others for continual support, and experience a deep fear of being separated from their caregivers. They are often described as clingy and needy, and will tolerate great lengths of abuse to maintain support from others. Counselors need to be aware that these individuals can become overly reliant on counselors and need help to develop their own self-confidence and ability to make decisions.

There has been much discourse about the classification of personality disorders in the DSM-5 and the level of clinical utility. This critique has brought about an alternative model for diagnosing such disorders. Two elements within the alternative model considered are: 1. Level of personality functioning which is measured using the level of personality functioning likert scale and 2. Pathological trait taxonomy which is measured using the trait-based Five-Factor Model (FFM). This alternative model provides a dimensional aspect of diagnosing personality disorders which proves to be quite useful and lowers co-occurrence with other diagnoses.

Reflections from Dailey et al. Chapter 17

Counselors are encouraged to be competent with navigating the DSM-5. The professional field of counseling is the largest consumer of the manual and once understood accurately, the manual provides a solid framework for clinical utility. Counselors are constantly seeking out ways to empower their clients and provide key opportunities for psychoeducation. Some of the major changes highlighted in the DSM-5 include the Cultural Formulation Interview and helpful recommendations to limit over - reliance on Not Otherwise Specified (NOS) diagnoses. Additionally, the change from roman numerals to arabic for numbering the DSM is of great significance on the part of the researching clinicians who intend to frequently update the DSM (e.g DSM-5.1, DSM-5.2) (Dailey et.al. 2014).

I found it especially interesting that there has been a major shift toward cultural appreciation and understanding. In addition to an individual's biopsychosocial profile, their culture provides a context that truly helps counselors see the complete picture. I agree with their efforts to raise awareness of the role culture plays and actively expect clinicians to be sensitive to this aspect in their practice.

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

The mandate is clear, counselors and all mental health professionals need to be completely familiar with the DSM-5. Firstly, understanding the manual and secondly navigating it properly both contribute to an accurate diagnosis. With an accurate diagnosis and solid case conceptualization, counselors are better able to apply evidence-based treatments and improve overall outcomes in counseling. Effective counseling is no longer only a personal goal, but a requirement for third party funders. When counselors understand the DSM-5 and feel competent, they can provide advocacy for those who need that support, and conduct research to contribute to the evolving mental health field. One of my personal goals is to educate and train other individuals who are interested in the field. The conviction and strong support to read and apply the DSM-5 is a characteristic that I intend to pass along. The DSM-5 provides a universal language for all clinicians to interact, and it is imperative that counselors remain fully aware of its evolution and paradigm shifts.

Conclusion

This paper has provided a wonderful opportunity to research and learn the details of several disorders and the history of the DSM. To read about the first DSM and all of the changes since then demonstrates that mental health is ever-evolving and the discovery is insightful and

beneficial. Research throughout both texts continues to highlight the reminder of suspending one's judgement, and paying careful attention to solidifying a diagnosis or case conceptualization. This paper has really helped to strengthen my resolve to remain steadfast in this work and provide effective counseling.

I found it intriguing to read and highlight from the Gabbard text the corresponding psychotherapeutic and pharmacological treatments. Although as a counselor, I tend to shy away from a medical model perspective, it is helpful to be familiar with commonly prescribed medications and recognize their names and uses. I am very excited to continue this journey of learning and finding positive ways to contribute to the fascinating and life-changing work in Mental Health.

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