

**Reflection, Critical Analysis, and Synthesis Paper**

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I have no known conflict of interest to disclose.

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### **Abstract**

Having an exhaustive understanding of how to effectively treat individuals via the DSM-5 is ethical and promotes best practices. This reflection, critical analysis, and synthesis paper will examine, compare, and contrast chosen psychological disorders from Dailey et al. and Antony & Barlow texts and will integrate my understanding about key elements from both texts that are most important to me concerning those chosen conditions. The conditions that I most frequently treat in my therapeutic practice and/or desire to learn more about are as follows: Depressive Disorders, Anxiety Disorders, and Trauma- and Stressor-Related Disorders. With all these elements considered, the main purpose of this paper is to discuss, examine, and integrate key concepts from both texts, in order to show my understanding of how to demonstrate best practices using the DSM-5.

*Keywords:* Depressive Disorders, Anxiety Disorders, Trauma- and Stressor-Related Disorders, DSM-5, best practices

### **Reflections on Chapter One, Dailey et al.**

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which was published by the American Psychiatric Association, is a manual that must be understood thoroughly and used effectively by those who provide mental health services in any capacity. It is important that mental health practitioners, as well as researchers, understand the fifth edition of the DSM and how to do some of the following things: recognize the client's presenting issues, develop client conceptualization, accurately diagnose the client, and use a reliable and verifiable assessment tool in the treatment process (2014). It is also important that everyone understands the changes, which have taken place in the fifth edition of this manual. It is further important that everyone understands how these changes affect the efficacy of the entire treatment process.

Several things caught my attention about chapter one. It is important that the DSM is used appropriately by those in either private practice, agencies, and hospitals for third-party billing, as well as for specific record keeping and reporting (2014). I realize that the overall effectiveness of the entire treatment process relies on giving an accurate diagnosis based on current DSM-5 criteria. With this in mind, I have learned from the authors that an essential element of a professional counselor's identity is related to the counselor's ability to thoroughly understand and to responsibly use the DSM-5, which is also an important element of interdisciplinary communication (2014).

The authors discussed about the challenges and controversy, which accompany using the DSM-5. It is important to keep in mind that each client is different and cannot just be grouped into a fixed category. Each client is affected by sociocultural issues, which must be taken into consideration. These sociocultural issues can affect each client similarly and differently and must be taken into consideration in the entire treatment process.

Overall, the authors did a great job in explaining their reasons for writing this book. They discussed and outlined the timeline for the development of the DSM-5, discussed the American Counseling Association's advocacy role in the process, shared some of the major changes and eliminations in the current DSM-5, and presented the readers with a guide as to how each disorder would be addressed in the following chapters. I felt more prepared for this learning process after reading chapter one.

### **Reflections on Chapter Two, Dailey et al.**

In chapter two, Dailey et al. did a great job in discussing in detail the structural, philosophical, and major diagnostic changes in the DSM-5. It appears that a great deal of work was put into explaining to the reader about the development of the DSM- 5. I learned that the American Psychological Association first published the DSM in 1952 in its first attempt to systematize “the classification of mental disorders” (2014). I believe that it is important to understand the reason(s) why the DSM was first created and how it has changed and developed with each publication. History is so important in understanding how and why we use the DSM-5 today.

The authors also did a fantastic job in discussing the various changes, similarities, and differences between each publication of the DSM. I learned that the DSM-I consisted of three psychopathological categories, along with 106 narrative descriptions of disorders (2014). The DSM-II consisted of eleven categories, along with 182 disorders (2014). The DSM-III presented descriptive diagnoses, presented the multiaxial system, and emphasized the medical model (2014).

The DSM-IV was comprised of 365 diagnoses with 886 pages and included sixteen diagnostic classes, one general section, and eleven appendixes (2014). The DSM-IV-TR (“text

revision”) was developed to assist in differentiating people from their diagnosis (2014). The DSM-5 consists of three sections, twenty diagnostic classes, two general sections for medication-induced problems and other conditions and includes the ICD-9-CM codes, as well as the ICD-10-CM codes (2014). It also includes changes such as the inclusion of cultural sensitivity, a hybrid dimensional-categorical model for diagnosing personality disorders, and a new nonaxial system, as well as discontinuing the Global Assessment of Functioning.

Reading this chapter challenged me to examine my own philosophy pertaining to the use and view of the DSM-5. The change of focus from the medical model to the biological model is in alignment with my own philosophical views. Also, the change from using diagnostic categories to also using dimensions makes practical sense. I believe that it is important not to just categorize someone but to also consider that person’s experience, how often the client deals with the issue(s), how long it lasts, and how much the issue impacts that person’s functioning.

So much information was presented in this chapter. The writers presented valuable information for me to consider as a therapist. With all the changes in the DSM-5, I can understand how some might fear the changes that the DSM-5 present, especially with changed criteria and how this affects professionals in the field. It is important that everyone understands the changes that have been made, in order to provide treatment that is both ethical, reliable, and effective. Only time, as well as more data, will verify the overall efficacy of the DSM-5.

### **Reflections on Chapter Three, Dailey et al., and Antony & Barlow, Chapter Eleven**

Depressive disorders are explored in both the Dailey et al. and the Antony & Barlow texts. In terms of depression, it is important to realize that depression can be debilitating and can greatly affect and impair the individual’s daily functioning. Both texts recognize that the general population is affected by depression.

In the Dailey et al. text, it is mentioned that about 10% of the general population deals with depression, which supports the frequency of how many people are being seen for depression (2014). It is also mentioned in this text that major depressive disorder (MDD) is one of the most regularly diagnosed of the mental health disorders (2014). In the Antony & Barlow text, it is stated that clinicians cite that one of the most regular issues they come across is major depressive disorder (2020).

Both texts support the fact that women are greatly affected by depression. The Dailey et al. text writes that depression is seen less in men and more in women (2014); however, the Antony & Barlow text writes that that ratio of women to men, who deal with depression, is nearly doubled (2020). This is pertinent information to keep in mind when dealing with clients.

Comorbidity is also discussed in both texts. In the Dailey et al. text, comorbidity is discussed as a normal element with depression (2014). In the Antony & Barlow text, the authors discussed about psychiatric and medical comorbidity, which they attributed to greater psychosocial impairment and misdiagnosis of depression (2020).

Cultural sensitivity, which is discussed in both texts, is something that must be taken into consideration. The client is affected by his/her culture and by what is generally experienced in that culture. What is alarming is that African Americans and Latinos, who either might have work-related issues, are unmarried, or do not have health insurance, are more regularly given a depression diagnosis (Dailey et al., 2014). According to research, particular cultural groups are more prone to present with somatic, cognitive, and/or affective symptoms than other groups (Antony & Barlow, 2020).

Something that caught my attention in the Daily et al. text is that the writers shared about the need for counselors to be aware of institutional racism, which could affect the way

professionals relate and give care to the client (2014). I do not believe that we discuss this issue enough. We must be culturally sensitive. We also must be aware and recognize institutional racism, which could be presented from any professional of any cultural background. Institutional racism is still racism, is unethical, and can affect the service given to the client, which is a violation of the ACA Code of Ethics (American Counseling Association, 2014).

While both texts did overlap and discuss about some of the same things, they were different in their focus and delivery of information. In the Dailey et al. text, the focus was more on the following things: major changes found in the DSM-5; differential diagnosis; etiology and treatment; implications for counselors; cultural considerations; coding, recording, and specifiers; and essential features, along with case examples (2014). The authors discussed about the importance of using evidence-based treatments to deal with depressive disorders; however, they did not go in depth about the assessment tools.

Unlike Dailey et al., Antony & Barlow went into much depth about the assessment tools that could and/or should be used in the treatment process. They presented the information, discussed about the reliability and validity of the instruments used in the treatment process, gave their opinions on which diagnostic tools are in alignment with the DSM-5, and discussed about the overall effectiveness of each instrument discussed.

I learned about the strengths and weaknesses of the various assessment tools discussed and presented in the Antony & Barlow text. The Structured Clinical Interview (SCID-5) for the DSM-5 is one of the instruments suggested to be used for depression. This instrument is a semistructured interview that can be used to diagnose the major diagnoses, and it has three versions that can be used, depending upon the exact location and time allotment (2020). I also learned about the Montgomery-Åsberg Depression Rating Scale (MADRS). It is a clinician-rated

scale of depression, is very familiar, is heavily used, and has excessive research and clinical value (2020).

Depressive Disorders was chosen because I have a lot of clients in my private practice, who deal with depressive disorders. I am a student of learning and feel that the information presented in both texts are enlightening and thought-provoking. Overall, I have a much broader understanding about the importance of the DSM-5, about the importance of using various diagnostic instruments, and about the importance of using the information learned to provide my clients with the best care that I can as a professional counselor.

### **Reflections on Chapter Five, Dailey et al., and Antony & Barlow, Chapter Eight**

Generalized anxiety disorder (GAD), which belongs to the overarching family of anxiety disorders, is explored in the both the Dailey et al. and the Antony & Barlow texts. It is important to understand that anxiety itself is an expectation of an upcoming threat (Dailey et al., 2014). According to the Dailey et al. text, generalized anxiety disorder is an extremely familiar mental health disorder (2014). I chose this disorder because I have a lot of clients in my practice, who are dealing with an anxiety disorder. In addition to this, I wanted to learn more about generalized anxiety disorder.

Both texts have several things in common. They both agree that worry is the greatest identifiable element of generalized anxiety disorder and that this worry can severely impair the individual's functioning in society. They also both discuss that the diagnostic criterion for this classification is that the worry or anxiety must also occur in various situations and must be experienced for most days for no less than six months. Antony & Barlow wrote that this criterion was created in order to really differentiate this disorder from other disorders (2020).

Comorbidity is another aspect that both texts discuss. According to the Dailey et al. text, generalized anxiety disorder can easily be misdiagnosed with other anxiety disorders, as well as OCD, adjustment, psychotic, depressive, and bipolar disorders (2014). In alignment with this statement, the Antony & Barlow text states that the comorbidity rate with GAD is high, that it mostly co-occurs with major depressive disorder (MDD), and that psychiatric, as well as medical, comorbidity must be considered in addressing the client's needs (2020).

Although the Dailey et al. text did not speak in great lengths about generalized anxiety disorder in this chapter, the writers focused on various anxiety disorders. They discussed about the major changes found in the DSM-5, the differential diagnoses, cultural and special considerations, and about coding, recording, and specifiers for each anxiety disorder. Regarding anxiety disorders, they mentioned that cognitive-behavioral therapy (CBT), as well as behavior therapy and relaxation training, has been proven to be most effective in the treatment of individuals dealing with anxiety disorders (2014).

In the Antony & Barlow text, the writers went into more detail about the etiology and about the various treatment strategies in treating generalized anxiety disorder. One of the things mentioned is that this disorder is moderately heritable and can be affected by neuroticism (a personality trait), as well as by genetic implications (2020).

The writers also acknowledged the importance of cognitive-behavioral therapy (CBT), stating that this is the most significant, evidenced-based treatment for this disorder and that this therapeutic modality should be implemented first when treating someone with this disorder (2020). The writers also endorsed newer CBT-based practices, including mindfulness and acceptance, and pharmacology in treating generalized anxiety disorder (2020).

One of the things that really impressed me was Antony & Barlow's thorough discussion about the treatment process pertaining to treating someone with generalized anxiety disorder. Because of the nature and comorbidity of this disorder, many things must be observed and taken into consideration. Some of those things are as follows: the frequency, duration, and intensity of the worry; if the worry can be attributed to another mental health disorder, substance use, or medical situation; and the continuous assessing of suicidal ideation in treatment (2020).

One therapeutic tool in treating someone dealing with generalized anxiety disorder is the Generalized Anxiety Disorder-7 (GAD-7). It is a seven-item scale that is reliable, valid, and provide valuable information for those in primary and managed care environments (2020). It is also self-reporting and can be used in conjunction with other therapeutic assessment tools. The discussion about this is valuable to me because Therapy Notes just offered this assessment tool in my client portal. I have used it in different therapeutic settings and believe that this tool can assist in the treatment process.

Generalized anxiety disorder is complex and can be challenging; however, if the clinician can use the correct tools and instruments to measure the client's symptoms more accurately, efficacy can occur in the client's treatment process. Both texts presented a great job in discussing about the overall scope of anxiety; however, the Antony & Barlow text went into further detail about generalized anxiety disorder and about the entire treatment process. The treatment of generalized anxiety disorder is continuous, can be challenging, and should implement an array of different therapeutic tools, in order to fully address this disorder and to have a more efficacious outcome.

**Reflections on Chapter Seven, Dailey et al., and Antony & Barlow, Chapter Ten**

Trauma- and stressor-related disorders are explored in both the Dailey et al. and the Antony & Barlow texts. A single, traumatic or stressful experience can negatively affect someone physically or emotionally, leaving them significantly impaired and unable to function daily (Dailey et al., 2014). Antony & Barlow referred to these events as PTE's, potentially traumatizing events (2020).

Both texts indicate that the trauma- and stressor-related disorders is a new category within the DSM-V. PTSD and acute stress disorder, which were once categorized with anxiety disorders in the DSM-IV-TR, have been placed in this new category due to the categorical changes in the DSM-5 and the grouping of conditions with the same shared etiology (Dailey et al., 2014). Dailey et al. also shared that new criteria to diagnose impairments caused by trauma or stress must be studied, in order to be able to correctly diagnose these disorders (2014).

Something to keep in mind is that two of the trauma- and stressor-related disorders have been assigned specifically to children. They are as follows: reactive attachment disorder and disinhibited social engagement. These diagnoses are given to children, who have attachment issues due to exposure to trauma or neglect (Antony & Barlow, 2020). This is valuable information to know when treating children, especially children with whom I might work with in the future.

Since people can experience traumatic and stressful events throughout their lifetime, comorbidity can be high and can affect the severity of the symptoms, especially concerning PTSD (Antony & Barlow, 2020). The symptoms can be indicative of many other disorders. Therefore, it is so important that clinicians understand the new DSM-5 criteria in differentiating trauma, its level of severity, and its impairment in the life of the individual; something which both texts encourage.

Considerations must be given regarding trauma- and stressor-related disorders and PTSD. Cultural sensitivity is a consideration that must be acknowledged. Different ethnic groups can be exposed to different levels of trauma and stress daily, and the clinician must understand that the client's symptomatic presentation might be specific to that client's culture (Dailey et al., 2014).

Another consideration that must be considered is that some people can be exposed to potentially traumatic events due to their line of work and can develop PTSD. Police officers, firefighters, and those in the military are some examples (Antony & Barlow, 2020). In addition to this, even those who have experienced mass violence and/or natural disaster are susceptible to developing PTSD (Antony & Barlow, 2020).

Antony & Barlow shared some great insight into some of the following things: the diagnostic assessment tools that can be used; the implementation of a structured clinical interview; the careful use of exposure therapy; and the importance of screening, assessing, and monitoring effectiveness in the treatment process (2020). The Clinician-Administered PTSD Scale (CAPS-5) is discussed because of its reliability in the diagnosing of PTSD; however, Antony & Barlow suggest that the Primary Care PTSD Screen (PC-PTSD-5) and the PCL-5 are used in the primary care settings due to their psychometric results and usability (2020).

Something to consider is that assessing, evaluating, and monitoring PTSD is not an easy task. From this reading, I realize the importance of implementing best practices in treating PTSD, as well as trauma- and stressor-related disorders. I must learn more, in order to remain ethical and effective in my practice.

Overall, the authors did a great job in discussing key concepts pertaining to this order and PTSD. I chose this disorder because I deal with a lot of clients who present with adjustment disorder and because I wanted to learn more about this category of disorders. While both texts

presented valuable information, Antony & Barlow went even further and focused specifically on PTSD. I realize that screening and assessing are so important in the treatment process. Today, a gentleman, dealing with PTSD, called me. The information I have learned will be put to great use.

### **Reflections on Chapter Sixteen, Dailey et al.**

Chapter 16 is interesting and thought provoking. Personality disorders are discussed with present diagnostic criteria found in Section II and with possible future diagnostic criteria and conceptualization that integrates categorical and dimensional elements in Section III (2014). The authors make sure that the reader understands that the information in Section III is only a proposal and that they believe that the current criteria to diagnose personality disorders will be changed soon.

One of the interesting facts is that the ten personality disorders presented in Chapter 16 all have biological etiology in common. They are also grouped by the symptoms they present (2014). Based upon my reading, it appears that the following elements can be attributed with personality disorders. They can negatively affect and impair the client's ability to function. They can overlap seriously and present with comorbidity (2014). They also are hard to be diagnosed by clinicians, appear to be treatable via the therapeutic alliance, and appear to lack empirical support for best of practices involving varied treatment approaches (2014).

With these things in perspective, I can understand why the DSM-5 Personality and Personality Disorders Work Group deemed it necessary to attempt to address these issues and challenges. Even though their proposed model was not accepted into the DSM-5, it appears that this proposal just might replace the criteria for diagnosing personality disorders, especially since it has been included in Section III of the DSM-5.

Two concepts that really caught my attention are the discussions about differential diagnosis and cultural considerations concerning each personality disorder discussed in this chapter. Concerning differential diagnosis, I now understand more importantly about comorbidity amongst personality disorders and how important it is to make sure that the symptoms that the clients present with are not due to another factor. Their symptoms might be due to medical conditions, medications, or even substance use. I have also come to realize that absence or presence of diagnostic criteria can rule out other personality disorders. Being aware of these considerations can help in creating accurate diagnoses, effective treatment plans, and positive and verifiable outcomes.

The conversations about cultural considerations are informative, enlightening, and very much needed. As clinicians, we must be more aware about how a client's culture, family, and religious beliefs play a role in his/her perceived behavior and symptoms. A negative symptom in one culture might be the norm in another culture, and without cultural sensitivity, the clinician can misdiagnose the client. So, in providing an effective and holistic treatment experience, the individual's culture must be understood and must be observed in the treatment process.

Regarding the proposed model for diagnosing personality disorders, it is a lot to digest. Six personality disorders are listed in Section III of the DSM-5. Paranoid, schizoid, histrionic, and dependent personality disorders were removed due to lack of clinical use and lack of validity, as well as comorbidity levels (2014). As with any change, I believe that it is good to include levels of dimension in assessing the client. I also believe that if this proposal replaces the current DSM-5's criteria for diagnosing personality disorders we are going to have to become flexible, in order to attempt to meet the needs of the client and to continue to provide treatment that is ethical, culturally sensitive, and effective holistically.

Overall, chapter 16 is interesting and informative. It is well written. I believe that we must keep in mind that the ultimate goal is to help to improve the client's life and ability to improve. We must be open learn and differentiate the symptoms we see, while at the same time being aware of other factors that might affect the client's behavior.

### **Reflections on Chapter Seventeen, Dailey et al.**

Counselors are affected by the changes in the DSM-5 in various ways. The practice implications for counselors are many. In order to preserve the efficacy of the treatment process, counselors are going to have to become willing to learn, understand, adapt, and implement the changes presented in the DSM-5.

From this reading, I learned that the professional counseling identity has been greatly affected by neurobiological foundations and by the change to nonaxial diagnosis (2014). These two movements have become controversial for the changes that they propose. The concept of mental disorders became an issue of much debate, especially with the reconceptualization and restructuring of disorders (2014). An example of this is in the restructuring of ADHD from the Disruptive Behavior Disorders chapter to the chapter dealing with Neurodevelopmental Disorders (2014). I can imagine that this change frustrated those, who have been in the counseling profession for years. It appears that people are not quite as receptive to the prospect of change, especially when they have become comfortable.

The move to nonaxial diagnosis has resulted in several changes, which include providing a more biological view of disorders and no longer separating mental from medical disorders when assessing the client (2014). Regarding this change, I was impressed by the writers encouraging professional counselors to continue to provide effective and meaningful service to

the client. Like the writers discussed, the use of nonaxial diagnosis does not have to affect the level of service and the treatment process that is provided to each client.

One of the interesting things in this chapter is the discussion about the removal of NOS diagnoses from the fifth edition of the DSM. I most recently worked in the Baltimore City jail for almost three years as a mental health therapist. They have not updated their EPHR from the DSM-IV to the DSM-V. I came into this profession right after the DSM-5 had been published. I came across NOS diagnoses all the time while working at the jail, but in my private practice, I use *other specified* diagnosis when the client's symptoms can be diagnosed in a specific category but do not have enough diagnostic criteria for full consideration for the mental health diagnosis.

Other interesting discussions in this chapter pertain to coding and increased subtypes and specifiers. First, I learned a lot about coding from the information provided and about why ICD-10-CM codes were developed. Next, the use of subtypes and specifiers seems practical and makes sense. I feel that it presents broader options that the clinician can use to diagnose the client. However, one of the most important statements in this chapter is the writers' statement that professional counselors are responsible for comprehending and implementing the changes made in the DSM-5, as well as for advocating on the behalf of best practices (2014).

This chapter has made me even more aware about the changes that have affected counseling. Whether the change is minor or major, someone is going to either feel unhappy or slighted and challenge the proposed changes. What might appear to be practical for some might appear to be unpractical and unthinkable for others. Changes in this field appear to be constant; however, the most important thing for us as professionals is that we continue to make necessary adjustments, learn and implement these changes as professionals, provide ethical and best practices for clients, and advocate as professional counselors.

### **Implications in the Field of Professional Counseling**

There are many implications for counseling, supervision, counselor education, research and scholarship, and leadership and advocacy in the field of professional counseling. Our work is never done! Proposed advancements in the DSM-5 will continue to advance because progress never stops. Therefore, it is imperative that we embrace and recognize the key concepts pertaining to adequately assessing, diagnosing, and monitoring effectiveness in therapy. Just because it worked in the past does not mean that it is best practices by today's standard (DSM-5).

Next, we must be able to understand and identify the major mental health diagnoses so that we can effectively and ethically teach others how to become effective counselors. We cannot teach others to become effective if we are not effective ourselves. This effectiveness comes from actively engaging with the DSM-5.

We also must be willing to learn. This comes with remaining students of learning and being willing to integrate that new knowledge with what we already know and to implement that knowledge into everything that we do in the field of professional counseling. Becoming a leader means becoming a servant, being willing to give and to receive, and being willing to fight for what you believe. Finally, empathy and cultural sensitivity is needed. The client's cultural background is important and must be taken into consideration. To be effective, we must view the client holistically.

Completing this assignment has been life changing. I reflected, analyzed, and integrated the information from both texts. I learned more about the DSM-5 and about my chosen mental health diagnoses than I had known before. My desire is to be effective, ethical, and implement best practices via the use of the DSM-5. I realize that there is so much more to learn, and I am humbled by this assignment.

### References

American Counseling Association. (2014). *ACA code of ethics*.

<https://www.counseling.org/knowledge-center>

Antony, M. M., & Barlow, D. H. (2020). *Handbook of Assessment and Treatment Planning for Psychological Disorders* (3<sup>rd</sup> ed.). The Guilford Press.

Dailey, S. F., Gill, C. S., Karl, S. L., & Barrio Minton, C. A. (2014). *DSM-5 Learning Companions for Counselors*. American Counseling Association.