THE Pocket Guide TO THE DSM-5-TR™ DIAGNOSTIC EXAM

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Preface

You help others when you use the *Diagnostic and Statistical Manual of Mental Disorders*, Text Revision (DSM-5-TR; American Psychiatric Association 2022), an expansive catalog of mental illness, as a way to seek understanding of the people you meet as patients. For each illness, it provides diagnostic criteria and discusses the disorder from perspectives as diverse as culture, development, gender, genetics, law, and temperament. This book, *The Pocket Guide to the DSM-5-TR Diagnostic Exam,* is a pragmatic companion, a map for using DSM-5-TR when encountering another person for a diagnostic interview. This book is no replacement for either DSM-5-TR itself or psychiatric interview textbooks (see, e.g., MacKinnon et al. 2016; Shea 2017; Simpson and McDowell 2019; Sullivan 1954), but turns DSM-5-TR into a tool for an impactful diagnostic interview.

I often interview patients with students, trainees, and fellow practitioners, and I wrote this book so interviewers at all levels of experience could incorporate the structure of DSM-5-TR into their patient encounters. This guide follows the structure of DSM-5-TR. In the first section, I introduce the diagnostic interview. The first and second chapters address the goals of a diagnostic interview. The third chapter provides an efficient structure for learning the diagnostic interview. The fourth and fifth chapters describe how DSM-5-TR alters the interview. In the second section, I operationalize DSM-5-TR criteria for clinical practice. In the third section, I include diagnostic tools and additional information.

Taken as a whole, this book helps a clinician accurately diagnose a person in mental distress while establishing a therapeutic alliance, which remains the goal of any psychiatric encounter, even one as brief as a diagnostic interview.

Before beginning, a few words about language. In this book, because personhood precedes illness or consumption, I use the term *person* to describe the object of the initial diagnostic interview. When possible, I use gender-neutral terms for the person and the interviewer, but when doing so is grammatically awkward, I use the singular *they*. When speaking about a person who has entered psychiatric treatment after an initial interview, I use the term *patient* because it acknowledges the vulnerability

of the person in treatment and the responsibilities assumed by mental health professionals when they care for patients (Radden and Sadler 2010). By using *patient*, I am not endorsing medical paternalism. Rather, I am emphasizing that the particular and protected relationships that develop in clinical encounters are better described as therapeutic relationships between a patient and clinician than as therapeutic contracts between a consumer and provider.

Acknowledgments

This book began out of my fumbling attempts to speak with people in mental distress, and is designed to improve those conversations, so I thank all the patients, students, and teachers I learned from along the way. Discretion prevents me from naming the patients. The passage of time impedes me from naming all the students. So I thank the teachers whose habits I try to emulate: Lossie Ortiz, Betsy Bolton, Andrew Ciferni, Stanley Hauerwas, Don Spencer, Sue Estroff, Amy Ursano, Gary Gala, David Moore, Julia Knerr, Karon Dawkins, Joel Yager, Eva Aagaard, Robert House, Vince Collins, Abby Lozano, Gareen Hamalian, and Michael Mizenko. Finally, I thank Melissa Musick, Melanie Rylander, and Helena Winston for reading (and improving) drafts of this book.

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SECTION I

Chapter 1

Introduction to the Diagnostic Interview

I no longer remember the author, but I never forgot her lesson. We shape each other with our questions. The author wrote about being out in public with her granddaughters. Strangers would approach her, unbidden, to tell her how sweet her granddaughters looked or how well they were dressed, and the author experienced grandmotherly pride. Then, one day, she encountered an older woman who, upon meeting the author's grandchildren, bent down and spoke directly to the girls, but not about their appearance. "What are you reading?" the stranger asked. A conversation between the stranger and the grandchildren ensued. The author was struck by the different ways that the stranger engaged the children: by asking after the books they favored rather than the clothes they wore, she was asking after how they understood their books instead of how they dressed their bodies. It is a different encounter for a young girl to be spoken *with* about what she is reading than to be spoken *of* regarding her appearance.

I am no grandmother, but her lesson surely applies to psychiatrists like me. When we ask questions of a person experiencing mental distress, we shape our experience of them. When my first question is about suicide or psychosis, I am asking a person to consider their mental distress.

From a practical perspective, this is apt because people encounter clinicians when they are experiencing mental distress.

When a person is experiencing mental distress, their first psychiatric encounter is often confusing or frightening. To a greater degree than in other areas of medicine, a person often has to overcome a series of obstacles before they are evaluated for mental distress (Radden and Sadler 2010). The obstacles can include access, expense, fear, and stigma, but once a person overcomes these particular hurdles, they deserve an encounter that acknowledges and names their suffering while initiating a working relationship. Although there are various ways to

account for mental suffering, this book describes use of the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association 2022), the newest version of the common diagnostic language spoken by mental health professionals. DSM-5-TR has many perceptive critics (see, e.g., Allsopp et al. 2019; Caspi et al. 2020; Hayes and Hofmann 2020; Kendler 2014b; Kendler 2016; Raskin 2019). This book does not presume that DSM-5-TR is flawless or final, but that it is a shared way of organizing a psychiatric encounter into a diagnosis that contemporary professionals can pragmatically employ while seeking understanding of another person (Kinghorn 2011).

Understanding a person with mental illness who becomes a psychiatric patient is a remarkable challenge. People who become psychiatric patients often have overlapping vulnerabilities—including minority ethnicity, gender, language, race, religion, and sexual orientation—and fragmented experiences—including education, employment, housing, and relationships—that can be heightened by becoming a psychiatric patient. The psychiatrist Laura Roberts recently observed that a psychiatric patient's vulnerabilities "expand and augment the power of psychiatrists, psychologists, physicians, and mental health clinicians in subtle, complex, and often culturally determined ways" (Roberts 2016, p. 67). Clinicians need to be aware of the power they exercise in the clinical encounter so that their findings are something more than culturally predetermined.

Our challenge is that the findings of a psychiatric examination are neither as obvious nor as well understood as, for example, a subluxated shoulder, so mental health professionals need a common language like DSM-5-TR to describe these findings. Psychiatric findings are usually divided into *symptoms* (a person's subjective report of an abnormality) and *signs* (objective findings of an abnormality), but the most important thing is not the provenance of a finding but how a clinician uses clinical judgment to weigh symptoms and signs in the diagnostic process (King 1982). Although signs are generally considered more telling than symptoms, because they are observed, both are open to interpretation. When a person reports feeling tired, it can be a symptom of conditions as varied as anemia, anxiety, and apnea. When you observe a person crying, their tears may indicate glaucoma, grief, or grit trapped under a contact lens. A symptom like fatigue has little meaning independent of the person who is exhausted. A sign like tears matters because of the person whose cheek they fall upon.

Although many psychiatric symptoms and signs are particular to a specific mental illness, most are nonspecific—everyone has been fatigued, everyone has cried—and most people experiencing a psychiatric sign or symptom do not have a mental illness. Psychiatric symptoms and signs often exist in the borderlands between what is normal and what is pathological (Pierre 2010). Clearly, interpreting these symptoms and signs is difficult, and the risk of misdiagnosis is real, so you have an ethical responsibility to diagnose the suffering person before you as accurately as possible.

It is your responsibility to understand the relationships among the symptoms you elicit, the signs you observe, and their meaning for the person you meet. The effects can be profound, because although all illnesses threaten bodily integrity (Cassell 1991), mental disorders can compromise a person's ability to think, feel, and act. Because these faculties are centrally connected with a person's agency, sense of self, and identity (McHugh and Slavney 1998), mental disorders are often experienced as an existential threat. So when you see a person for the first time, remember that they may be internally asking something like, "What is wrong with me? Am I going crazy?" When you listen well to a person's report and identify the nature of the suffering, you can provide the relief that comes from giving a name to nameless fears.

The British internist Henry Cohen once wrote, "All diagnoses are provisional formulae designed for action" (Cohen 1943, p. 24). Diagnoses are provisional because they will be altered by further evidence. Diagnoses are designed because they are created by humans. Diagnoses are for action because they are intended to help a person effect a change in their

health that they could not make without the clinician's diagnosis. When a clinician diagnoses a person, they inaugurate treatment, which makes a range of medically regulated experiences available to the patient. Cohen went on: "Diagnosis then implies an understanding of disease processes, their sites and their causes" (p. 25). Diagnosis is not a label, but a way of understanding. "Only by skill in observation, and interpretation in the light of knowledge and experience, only by exercising care and patience and by cultivating wisdom and judgment can be reached that most desirable of medical achievements—ability to diagnose disease" (p. 25). Diagnosis is an act of prudential judgment seeking understanding of another person.

A clinician should name suffering as accurately as they are able, and DSM-5-TR is a learned attempt to improve our

clinical judgment as we characterize mental distress through the diagnoses of mental disorders.

DSM-5-TR improves the accuracy of psychiatric diagnoses by measuring the severity of a disorder, aligning diagnoses with the *International Statistical Classification of Diseases and Related Health Problems* (ICD) system, incorporating recent advances in the neurosciences, organizing diagnoses along developmental and lifespan pathways, increasing utility for forensic settings, reconceptualizing suicidal thoughts and behaviors, and deepening attention to culture, gender, and sex (American Psychiatric Association 2022). The edition revises the text of DSM-5, which was conceived by leaders of the American Psychiatric Association and other mental health groups, but ultimately crafted by many people organized into 6 study groups, 13 diagnostic work groups, and a task force of advocates, clinicians, and researchers (Regier et al. 2009). The resulting criteria were thrice made available online for public comment and field-tested for their reliability and validity (American Psychiatric Association 2013). DSM-5-TR extends their work by reviewing and revising the manual's text.

The signal advance of DSM-5-TR is the reengagement of social factors when diagnosing mental disorders. In this sense, it extends the DSM-5's introduction of "dimensions," or psychiatric symptoms that occur within and across specific disorders. Dimensions are discussed in Chapter 4, "Personalizing Diagnoses Through Dimensions," but in brief, they were introduced to reduce comorbidity and to begin moving toward a diagnostic system based on signs that indicate the dysfunction of neural circuits, rather than a diagnostic system based on symptoms. This marks a departure from previous DSM versions. DSM-5-TR extends this insight by adding other symptoms, chiefly suicidality, and by broadening the dimensions beyond symptoms, especially by increasing attention to how culture, gender, and sex affect a person's experience of mental health.

The authors of DSM began constructing diagnoses around the presence or absence of symptoms in the third edition (American Psychiatric Association 1980). This kind of diagnostic model is sometimes called a *categorical model,* because, based on the number of symptoms present, a person either does or does not have a mental illness that fits into a diagnostic category. Since DSM-III—the authors used Roman numerals for the first four editions but have switched to Arabic numerals to allow for the possibility of incremental updates (e.g., 5.1, 5.2)—the diagnostic criteria have included little mention of the cause of

any particular mental disorder. This focus on symptoms over etiology is sometimes called "the atheoretic principle" (Wilson 1993). Focusing on the description rather than the cause of a disorder allowed mental health professionals who disagreed about the etiology of mental distress to work together. DSM-III proved useful for mental health practice and research, so subsequent revisions maintained the categorical model (Decker 2013). Its problems became more apparent over time, however. DSM began to look like a birding guide, in which external characteristics identified the species to which a bird belonged, irrespective of the cause of these characteristics (McHugh 2007), and, even worse, a birding guide whose fidelity during actual use in the proverbial field was unknown (First et al. 2014).

Richard Bentall, a British psychologist, once observed that because happy people are statistically rare, exhibit cognitive distortions like optimism, and experience a discrete cluster of symptoms, happiness is a mental disorder. Accordingly, Bentall proposed that people experiencing happiness be diagnosed with major affective disorder, pleasant type (Bentall 1992). Bentall was joking about the diagnosis but serious about his critique of a diagnostic system that was sometimes unable to distinguish the normal, but rare, from the pathological (Aragona 2009).

To respond to such concerns, the authors of DSM-5 added dimensional assessments, while refining the categorical model that most current clinicians know. Dimensional assessments allow clinicians to chart the presence of latent threats and vulnerabilities, which can be expressed or abated through the dynamic interaction between a person and their lived environment. (A person's obsessive traits may be, for example, beneficial in a health profession training program, and deleterious in a relationship, while being observable in both situations.) Because DSM-5-TR will be widely adopted, I wrote this book to guide both novice and seasoned interviewers as they conduct a DSM-5-TR diagnostic examination using both categorical and dimensional assessments. The book includes a practical discussion about initiating and developing a therapeutic alliance during a diagnostic examination (Chapter 2), spends several chapters observing how DSM-5-TR affects the diagnostic examination (Chapters 3–5), and continues with an operationalized version of DSM-5-TR for the purposes of conducting a diagnostic examination (Chapter 6). As we begin, it is useful to consider the work product of a diagnostic interview.

Disorders Instead of *Illnesses* or *Disease*

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When you conduct a diagnostic interview, you generate a diagnosis, one of Cohen's "provisional formulae" for clinical actions. The diagnoses generated by a DSM-5-TR interview are called *disorders,* rather than *diseases* or *illnesses*. All three terms describe impairments of normal functioning, but the DSM system uses *disorders* to acknowledge the complex interplay of biological, social, cultural, and psychological factors involved in mental distress.

Physicians usually think in terms of diseases, which can be described as pathological abnormalities in the structure and function of body organs and systems. Patients usually present with *illnesses*, which are their experiences of pathological abnormalities or being sick. From a distance, diseases and illnesses may seem like the same experience viewed from the different perspectives of patient and physician. However, consider a condition such as

hypertension, which is often identified incidentally, without any associated clinical findings. To the diagnosing physician, hypertension is a chronic disease of the vasculature that increases the risk of stroke and a heart attack, but patients often do not recognize themselves as being sick or as having an illness. Conversely, a patient may present as feeling quite ill and describe themselves as homesick, but physicians do not recognize this as a disease. Diseases and illnesses are often divergent experiences, rather than merely different perspectives, as anthropologists have repeatedly documented (Oberlander 2019).

An anthropologist can also tell you that illness experiences are culturally constructed: different conditions will be recognized as diseases or illnesses in different places and times. However, to be recognized as suffering from a disease or an illness, an individual requires some kind of diagnosis, often a diagnosis from a physician.

When a particular culture recognizes a person as suffering from a condition that alters one's place in the community, the person enters what American sociologist Talcott Parsons (1951) famously called the "sick role." Parsons observed that a person recognized as sick is exempted from normal social roles. Sick people do not have to perform their usual roles, but the degree of exemption from their social roles is relative to the nature and severity of their illness, as well as to their ages and cultural roles. To use contemporary examples, the child gets to stay home from school for mild fever and diarrhea, but the adult

with back pain will receive disability only after experiencing years of refractory pain.

As part of the sick role, the sick person is usually not held responsible for their illness because sickness is believed to be beyond human control. So when a physician diagnoses a person with a sickness, the physician legitimizes the person's illness and admits them to the sick role (Parsons 1951). Admitting a person to a particular culture's sick role is part of what occurs when you diagnose a person's distress as a specific condition, and you need to remember that any diagnosis you assign to a person's distress has this cultural function.

Although all diagnoses have a cultural function, psychiatric diagnoses are especially complicated. Mental disorders result from biological, genetic, environmental, social, and psychological events and processes, and these etiological factors are involved to differing degrees in the development of different psychiatric diagnoses (Kendler 2012). Furthermore, because psychiatric diagnoses describe dysfunction in faculties believed to define one's personhood, they often constitute a threat to a person's sense of identity (Rüsch et al. 2005). Finally, the culture of clinicians and of medical facilities both shape the clinical encounter, altering what patients say and display and the outcomes they experience (Fiscella and Sanders 2016; Saini et al. 2017).

To recognize this complexity, the authors of DSM chose the term *disorder* to describe psychiatric diagnoses. *Disorder* can be broadly defined as a disturbance in physical or psychological functioning. The term is used elsewhere in medicine to describe genetic disorders and metabolic disorders. However, most diagnoses in medicine are called diseases rather than disorders, and naming psychiatric diagnoses as disorders reinforces a distinction between mental problems, *disorders,* and physical problems, *diseases* (Wallace 1994). We can see this when we consider that while a psychiatrist diagnoses a person with a "mental disorder," an internist does not diagnose a person with a "physical disease." Instead, an

internist tersely diagnoses a person with a "disease," illustrating how our use of the adjective "mental" before "disorder" implicitly endorses a division between the body and the mind.

The authors of DSM-5-TR reduce this division by naming, whenever possible, the etiology of a mental disorder. They do so, for example, with several neurocognitive disorders (e.g., Lewy body, traumatic brain injury, vascular disease). However, the definition and limits of most categories of disorder

remain broad. They range from illicit behaviors to particular pathological processes with well-characterized etiology, genetics, and prevalence. Therefore, the ambiguity about *what precisely a disorder is* remains.

Perhaps this is apt.

After all, diagnoses are an abstraction of a person's experiences and bear the marks of the era in which they were constructed and employed. Some diagnoses exist in one era and not another—hypertension, to return to our previous example, was not diagnosed in the 18th century because blood pressure could not consistently be measured. Some diagnoses serve one era's assumptions and not another's—as when psychiatric diagnoses were used to pathologize impoverished 19th-century Irish immigrants (Hirota 2017) and 20th-century Black activists (Metzl 2009) as part of racist, classist ideologies. Some diagnoses will be situated within psychiatry in one era and not in another. Some behaviors attendant to a seizure disorder, for example, can be attributed to epilepsy or to psychotic disorders (Sachdev 1998). Diagnoses serve cultural functions.

In this sense, using *disorder* to describe mental distress draws attention to how mental distress impairs a person's function, suggests the complex interplay of events that result in mental distress, and implicitly acknowledges the limits of our knowledge about the causes of mental distress. We do not know enough to be more precise. Instead, we can consider the ongoing use of *disorder* in our diagnostic systems as an opportunity for humility and a spur to further study. In the words of Ken Kendler, one of the most learned contemporary explorers of psychiatric diagnoses, "Tolerance for diversity and humility come with scientific maturity" (Kendler 2014a, p. 937).

The DSM-5-TR Definition of a Mental Disorder

The people you meet who have mental distress cannot simply wait for the precision that they and you desire—they deserve the best possible answers you can offer in the present moment. Cultural anthropologist Richard Shweder (2003) famously noted that anything observed from a single point of view is incomplete; incoherent when observed from all points of view at once; and empty if observed from no point of view at all. You have to take a particular point of view, but with the understanding that despite being necessary, the point of view you take is necessarily

incomplete. It is far easier to criticize definitions of a mental disorder than it is to construct an accurate, precise, and useful definition.

According to the authors of DSM-5-TR, a mental disorder is "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning." They distinguish a mental disorder from an "expectable or culturally approved response to a common stressor or loss, such as the death of a loved one." The authors caution, "Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual." This definition of a mental disorder, along with the authors' insistence that a diagnosis "have clinical utility" and "help clinicians to determine prognosis, treatment plans, and potential treatment outcomes for their patients" (American Psychiatric Association 2022), has several important implications for the diagnostic interview (Stein et al. 2010).

First, the definition characterizes a mental disorder as causing a clinically significant disturbance in a number of possible domains. This means that when you interview persons with mental distress, you need to explore the extent to which their distress significantly impairs their cognition, emotions, and behaviors. However, the definition does not characterize what constitutes a "significant" impairment. Without such precision, you need to define *impairment* with your patient based on how they functioned before the onset of the signs and symptoms with which they are presenting for evaluation. You might do this by asking the person to recall a time before the most recent onset of their distress and to describe the differences between their function at that point and in the present. Ideally, you will also obtain collateral information from people who know the person in multiple situations to help assess their premorbid ability and function. You may also want to use the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0), the disability assessment tool endorsed by the authors of DSM-5-TR (World Health Organization 2010), which is discussed in Chapter 12, "Selected DSM-5-TR Assessment Measures." Several other validated disability assessments are available, but whichever you use, you need to define *dysfunction* and *impairment,* along with their degree, individually for each person you evaluate.

Second, because the definition identifies dysfunction as occurring because of underlying disturbances in "the psychological, biological, or developmental processes underlying mental functioning," you need to assess all of these processes. The DSM-5-TR criteria offer clear guidance on how to elicit and organize symptoms of psychological processes, but provide less guidance for assessing biological and developmental processes. Because it is your responsibility to consider a person in full, you will need, at the least, to seek an understanding of the person's medical history and developmental stage. I briefly discuss ways to assess these processes in Chapter 3, "The 30-Minute Diagnostic Interview," and Chapter 8, "Six Questions to a Differential Diagnosis."

Third, the definition excludes dysfunction that is in some way expected. This can include responses to events such as the loss of an intimate relationship or employment—that is, events that induce mental distress in many people. The DSM-5-TR definition mentions "culturally approved" responses but does not define what constitutes either a culture or its approval, which further points to your need to assess the relationship between the symptoms you elicit in a

diagnostic interview and their context in a person's life. Therefore, you might ask the person, or their family, friends, partners, and peers, if their response is consistent with the responses of their culture, because you need to explore the cultural context in which the person with mental distress presents.

Fourth, the definition simultaneously excludes dysfunction caused by a disagreement between a person and their broader culture. A person's thoughts and behaviors may clearly be in conflict with those of their intimates or with their culture. Conflict in and of itself is not evidence of a mental disorder. A person can disagree with the leaders of their country, disengage from their faith community, or dislike their siblings without having a mental disorder. For a diagnostic interview, establishing a person's cultural expectations and baseline behaviors is important, especially when you are interviewing a person whose age, gender, culture, experience, faith, language, or lifestyle is different from your own—in short, almost everyone you meet. You should ask a person what their distress means rather than make assumptions about its meaning.

Fifth, the definition includes an important caveat: a diagnosis must be clinically useful. This caveat helps further distinguish DSM-5-TR from a birding guide, because even if a person endorses all the symptoms of a particular disorder, if the disorder does not usefully inform that person's diagnosis, treatment, or

prognosis, then the diagnosis is considered inappropriate. This requirement for clinical utility speaks to the pragmatic nature of DSM-5-TR, which is a diagnostic system designed to enable accurate and reliable communication of psychiatric findings, rather than to diagnose disorders simply for the sake of doing so.

The Questions Produced by a Diagnostic Interview

In reviewing the definition of a DSM-5-TR mental disorder, it becomes clear that the authors of DSM-5-TR left much undefined. This lack of definition necessitates, as happens so often in psychiatry, the exercise of practical wisdom (Radden and Sadler 2010). In the diagnostic interview, it means applying diagnostic categories to the irreducibly particular person before you. To define a mental disorder for the person before you, you need to seek a thorough understanding of the patient as a person. While a good diagnostic interview produces a diagnosis, it also generates questions you will need to ask as you seek understanding. These questions can relate to diagnosis, treatment, and prognosis.

At the conclusion of any diagnostic interview, you should generate a list of additional information you need for a more actionable diagnosis. This additional information can be as straightforward as collateral information from people who know your patient in other contexts, including reports from past psychiatrists, psychologists, therapists, counselors, primary care physicians, pastors, employers, coworkers, teachers, peers, friends, family, partners, and spouses. At times, you may wish to address particular areas of concern by administering additional diagnostic tests, such as physical or neurological examinations, or neuropsychological or personality tests. Before you administer additional tests, you should understand the strengths and limitations of each test and consider how a positive or a negative test result will change your therapeutic relationship. Finally, it is always useful to seek further

understanding of a person's coping strategies and their understanding of the etiology and treatment of mental distress. People *present* with their distress, but *they are not* their distress. So ask after their strengths, their passions—about the activities that constitute their flourishing (VanderWeele 2020).

Although DSM-5-TR is not a treatment manual, the diagnostic interview is a time to consider whether and what treatment

is indicated (cf. Hilt and Nussbaum 2016; Wang and Nussbaum 2017). With experience, you can initiate treatment in the interview by incorporating basic therapeutic techniques into your diagnostic interview. Many teachers recommend a classic text, *The Psychiatric Interview in Clinical Practice* (MacKinnon et al. 2016), to learn how to organize a psychiatric interview for the personality structure of your patient. If you feel presently unable to introduce therapeutic techniques into your diagnostic interview, you should at least begin mentally formulating the case and identifying resources keyed to the person's particular problems and strengths as you interview them. Ways to do so are discussed in subsequent chapters.

Finally, DSM-5-TR offers nothing in the way of prognosis to help a patient know what to expect of the treatment you recommend. You ought to offer reasonable hope to the person you interview. This hope should be informed by an evidence-based review of the scientific literature, your clinical wisdom, and your understanding of the person's premorbid functioning and of the available resources, but also by the possibility that the existing resources could be expanded through clinical advocacy. There are, after all, many kinds of clinical actions.

Conclusion

Critics of DSM-5-TR are concerned that it will be used as a psychiatric checklist rather than as a means for a comprehensive examination (see, e.g., McHugh and Slavney 2012). DSM-5-TR certainly can be received and misused that way. You can also employ it as one part of a comprehensive diagnostic interview that both characterizes the distress a person describes and helps in beginning to understand the person experiencing the distress. DSM-5-TR continues to rely on the experiences and symptoms reported by a person, but you can receive this as an implicit acknowledgment of the limits of the available knowledge about mental distress and an invitation to attend closely to each patient. In this fashion, your use of DSM-5-TR reflects your orientation toward the well-being of your patients, as well as your humility and willingness to revise your "provisional formulae" as you gain further insight and seek the ever-more fitting clinical action to which they aspire. In short, you can use a DSM-5-TR diagnosis both as an invitation to understand a person's mental distress and as the beginning of a conversation, rather than its conclusion, to create provisional formulas for clinical action.

Chapter 2

Alliance Building During a Diagnostic Interview

Every encounter with a person, even the first meeting, should be therapeutic. How can you accomplish this, even in a diagnostic interview? As discussed in Chapter 1, "Introduction to the Diagnostic Interview," accurately naming a person's mental distress is itself a response to a patient's suffering. A diagnosis initiates the therapeutic response to a person's distress and inaugurates a relationship in which you and your patient mutually commit to the patient's well-being. This relationship, called a *therapeutic alliance*, is the foundation of all psychiatric treatments and should be formed during a diagnostic interview.

When a patient and clinician mutually identify treatment goals and ally themselves in pursuit of those goals, they establish the alliance that mobilizes healing forces within the patient by psychological means. As the psychologist Edward Bordin wrote, in his seminal formulation, the therapeutic alliance includes "three features: an agreement on goals, an assignment of task or a series of tasks, and the development of bonds" (Bordin 1979, p. 25). The goal is the "why" of treatment, what the patient and clinician are working toward, whether it be recovery or remission. The task is the "what" of treatment, the activities that enable a patient to pursue health, whether they be thought records or titration schedules. The bond is the "how" of treatment, the kind of affective relationship that develops between clinician and patient, whether it be consulting or caretaking (Kinghorn and Nussbaum 2021). Your ability to form these alliances profoundly influences the efficacy of your work with the patient, as well as your satisfaction with and resilience in this work (Summers and Barber 2003).

Different therapeutic responses to a patient emphasize different aspects of the alliance (cognitive-behavioral therapy is, for example, more task-focused), but it is the strength of the alliance that consistently affects treatment outcomes. In a recent meta-analysis of hundreds of psychotherapy studies assessing

the care of more than 30,000 patients from around the world, researchers found that developing a therapeutic alliance had a positive, medium effect size on treatment outcomes with both face-to-face and internet-based psychotherapies (Flückiger et al. 2018). In a smaller meta-analysis examining the role the therapeutic alliance plays in the medication treatment of persons with serious mental illness—that is, bipolar disorder, major depressive disorder, and schizophrenia—researchers found that when a clinician improves their alliances with patients, in either inpatient or outpatient settings, patients experience better treatment outcomes. Roughly, the same medication prescribed for the same condition produces about a 10% better patient outcome if it is prescribed within a positive therapeutic alliance (Totura et al. 2018).

Anyone who wants to know how and why the same treatment can be more effective within a therapeutic alliance should read Jerome and Julia Frank's classic *Persuasion and Healing: A Comparative Study of Psychotherapy* (Frank and Frank 1991). The Franks spent their careers asking why different forms of therapy—psychoanalysis, cognitive-behavioral therapy, group therapy, and Alcoholics Anonymous—as well as shamanistic encounters and religious faith can all effectively motivate change. The Franks observed that most aspects of a person cannot be changed because most people have a fairly fixed set of assumptions about themselves and the world. If these assumptions are fixed, why do people seek out mental health practitioners? According to the Franks, people have maladaptive assumptions about themselves and the world. These assumptions repeatedly fail, which is demoralizing. The Franks write that the "major sources of demoralization are the pathogenic meanings patients attribute to feelings and events in their lives. . . . Effective psychotherapies combat demoralization by persuading patients to transform these pathogenic meanings to ones that rekindle hope, enhance mastery, heighten self-esteem, and reintegrate patients with their groups" (Frank and Frank 1991, p. 52). Even during a diagnostic interview, you can identify maladaptive assumptions and the resulting demoralization. You can also rekindle hope.

The Franks found that all effective forms of therapy identify a socially sanctioned healer, a demoralized sufferer who seeks relief from the healer, and a circumscribed relationship in which they meet. To provide effective therapy, you must identify with a particular theory and have an appropriate confidence in it.

The Franks concluded that therapy is a kind of rhetoric in which you stimulate emotional arousal to transform the meaning of an event. That transformation occurs only if you offer the patient a conceptual framework for making sense of their maladaptive assumptions and the resulting demoralization. You can effectively invoke serotonin receptors or the superego, so long as the framework is compelling to the patient and to you. You can begin this process in the initial interview (Alarcón and Frank 2011).

Think about your own life: Did you ever work with a teacher or coach who helped you master a skill you could not learn on your own? How were you motivated? What was your relationship with the motivator? Now think about a teacher or coach for whom you underperformed. How were you discouraged? What was the nature of that relationship?

Your own goal should be to foster relationships that motivate people to make therapeutic changes in their lives, changes they could not initiate without the therapeutic relationship you share.

This is not to say that you need to mimic your favorite coach, teacher, or anyone else for that matter. During my own training, many of us went through a painful period in which we began talking earnestly in faux therapist voices. We would greet each other guardedly, fearful that expressing any emotion or personal thought would fatally betray our faults. The less confident residents (guilty!) bought tweed jackets and parroted our faculty. The more confident residents quickly moved beyond this stage and established their own styles. They showed me that a confident Texan, an assiduous Ohioan, and a mannered South Carolinian could all be effective if they could connect with their patients. Diverse approaches and styles can be therapeutic; you will become a better clinician as you develop your own style.

After all, if accurately applying the DSM-5-TR diagnostic criteria in all their specificity is the *science* of psychiatric interviewing, then the *art* is forming a therapeutic alliance. In an evidence-based and artful diagnostic interview, you conduct a form of rudimentary psychotherapy in which you instill hope and provide appropriate support to a demoralized patient. As you assess a patient, your goal should be to initiate therapy, because this helps reinforce the patient's intentionality, directing their thoughts toward health (Mundt and Backenstrass 2005). Here are a few evidence-based and artful ways to form a therapeutic alliance during a DSM-5-TR diagnostic interview.

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Goals: The *Why* of Alliance Building in a Diagnostic Interview

When clinicians see patients, we often focus on what ails them, on their pathology. We ask after symptoms. We observe signs. We map them onto known disorders. We can build an alliance by mapping them onto specific, measurable treatment goals, as discussed in Chapter 10, "Mental Health Treatment Planning." Strive to instead leave the clinical encounter agreeing with the patient on *what matters most*, by asking yourself something like, "What are this patient's health goals, now and in the future?," and make sure you have a plan to prioritize the patient's goals (Zulman et al. 2020).

But remember: these goals are milestones along the way toward health, rather than health itself.

While we desire to know and name a patient's distress, the ultimate goal of a diagnostic interview is to encourage a patient's flourishing. The study of human flourishing has found evidence that cognitive exercises, behavioral changes, engagement in institutional and relational practices, and the addressing of psychological distress promote well-being (see, e.g., VanderWeele 2020). Seeking the well-being of the people we meet as patients is the ultimate *why* of the diagnostic interview.

Tasks: The *What* of Alliance Building in a Diagnostic Interview

A therapeutic alliance is also established by asking questions about the *what* of treatment, the tasks a person will undertake in pursuit of health. To do so, you need to establish a mutual framework for understanding the psychiatric signs and symptoms you elicit during a diagnostic interview. These framing questions simultaneously generate clinical information while building the therapeutic alliance.

There are many ways to do so, but I include two here. In the first instance, you build the alliance by asking about the patient's cultural experience of illness. In the second instance, you build the alliance by asking for an abbreviated version of their social history. Either method engages someone as a person before engaging them as a patient.

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The psychiatrist and anthropologist Arthur Kleinman spent his career reflecting on what it means for people of different cultures to meet during times of illness. He found that physicians often assume they know what the meaning of an illness is for an ill person. When Kleinman