

Introduction

This book is part of a series of books published by the American Psychological Association (APA) on the classification system known as the *International Statistical Classification of Diseases and Related Health Problems* (ICD) developed by the World Health Organization (WHO). As we describe in more detail in Chapter 1, the ICD has been the standard in medical classification internationally since the mid-19th century. It is now in its 10th edition (ICD-10; WHO, 2016), with the 11th edition scheduled for dissemination by the WHO sometime in 2017. As we discuss the ICD-10, if you have interest in learning about some projected changes and the development of the ICD-11, see Tyrer et al. (2011).

The ICD-10 was endorsed by the WHO in 1990 and adopted for use in most countries in the world by 1994 (WHO, 2016). The WHO allows each country to adapt the ICD for its own specific clinical needs. In the United States, that adaptation is referred to as the Clinical Modification, hence, the ICD-10-CM (National Center for Health Statistics, 2015).

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A Student's Guide to Assessment and Diagnosis Using the ICD-10-CM: Psychological and Behavioral Conditions, by J. Schaffer and E. Rodolfa
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On October 1, 2015, the United States switched from using the ICD-9 to using the ICD-10 because the limitations of the ICD-9, primarily in the number of diagnostic categories present, were becoming increasingly obvious and problematic. Although the ICD is fundamentally a list of causes of death, expanded to include morbidity, it is recognized that not all health-related problems fit into those two categories, so the ICD-10-CM incorporates the flexibility to include a variety of signs and symptoms that would end up in a patient's chart and about which gathering of health information could be of benefit. At the same time, unless the number of categories is limited, the system is not very helpful, so the ICD-10-CM provides a balance between comprehensiveness and practicality. The goal of the ICD endeavor has been to provide a specific category for any condition that either has importance to the well-being of the population or occurs with some frequency.

In addition, unbeknownst to many or most psychologists, it is not the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association (e.g., 2013) that is the standard classification system used by agencies of the U.S. government (e.g., Medicare, Medicaid) and by most private insurance companies—it is the ICD (specifically, ICD-9-CM until October 1, 2015, and ICD-10-CM starting on October 1, 2015). The change from ICD-9-CM to ICD-10-CM constituted a significant change in codes, as we describe in Chapter 1. Briefly stated, the codes used by the fourth edition of the *DSM* (American Psychiatric Association, 1994) and the ICD-9-CM were virtually identical. The development of the fifth edition of the *DSM* (American Psychiatric Association, 2013) led to some divergence in codes (i.e., the numbering system used to refer to specific diagnoses) and with the ICD-10-CM, the divergence has increased.

Thus, this series of books published by APA is intended to educate mental health professionals, psychologists in particular, in the use of the ICD system, specifically, the ICD-10-CM. The goal is to help mental health professionals understand the requirements for billing insurance companies under the ICD-10-CM and to assist them to become more consistent in their thinking and diagnostic procedures with an increasingly globalized psychology.

Welcome to Our World

This book, focused on the ICD-10-CM, is written primarily for graduate students and interns in psychology. Our specific goal is to assist in their preparation for the diagnostic tasks they will encounter as practicing psychologists in the very near future. In other words, this book has been

written to help students think like psychologists, including using critical thinking skills, and learn to use and apply the classification system of the ICD-10. However, we firmly believe that diagnosis is part of a broader enterprise for psychologists that includes, centrally, the assessment of the personality, social context, needs, problems, and strengths of the individuals with whom they work. Therefore, this book focuses to a large degree on assessment, placing the ICD-10-CM diagnostic system at the center of that assessment process.

To that end, the book comprises 10 chapters, in addition to this brief introduction. Chapter 1 presents a primer of the ICD-10-CM system, with the goal of providing the historical context for the ICD system and, more important, the specific steps one must take to arrive at the correct diagnostic code using the ICD-10-CM system.

Chapters 2 and 3 explore assessment and diagnosis and provide an overview of the numerous issues a psychologist should consider in the process of assessing an individual and arriving at a diagnosis. For the experienced psychologist, assessment of a person is an endlessly interesting and challenging process. The goal is, in the matter of a few short hours and with a limited number of psychological tools, to come to an understanding of a person, such that the goals of the assessment can be accomplished, whether the goals have to do with, for example, the provision of psychotherapy and the resolution of some problem; or the development of an assessment process resulting in a report to a court, as happens in forensic psychology; or responding to another professional who makes a referral. It is the complexity of trying to understand a complicated human being that makes the process interesting and challenging, even for the experienced psychologist. That complexity can be daunting to a student. Chapters 3 is our attempt to provide an outline of the process and some of the challenges of undertaking such a formidable task as trying to understand another human being. Obviously, these two chapters cannot provide everything that a student can and should know about assessment. Hence, supplemental resources that might be helpful are provided in Chapter 10. Chapters 2 and 3, however, provide a philosophical perspective regarding psychological assessment leading to the process of diagnosis, which requires knowledge and skill to carry it out in an appropriate and competent manner.

The remainder of the book relies on Chapters 4, 5, and 6 as its core. Each of these three chapters provides a case that serves as a basis for discussion of issues involved in the assessment process. These three cases, chosen in part with commonly used ICD-10-CM diagnostic categories in mind and in part on the clinical experiences of the two authors, cover three very different clinical situations. The first case, described in Chapter 4, is a referral to a graduate student clinic for assessment as part of a treatment process, and provides a consideration of issues related

to students providing psychological services. The second, described in Chapter 5, is a referral for an assessment in a medical setting, with the possibility of treatment follow-up. What is different from the first case, but common in the real world, is that very few specifics are provided with the referral, creating a challenge to know what should be done and how. The third case, described in Chapter 6, is a referral by an attorney. This referral has a very complex social history and presents with very challenging psychological issues. The referral is for an assessment without the potential for follow-up treatment. These three cases were conceived with the goal of providing a range of problems and situations that are typically seen in clinical practice. After describing each case, we discuss the process a psychologist undertakes in thinking about clinical cases, both in terms of how one approaches the assessment process, that is, what assessment methods to use and what type of data to collect, and subsequently how those collected data influence the diagnostic decisions and differential diagnoses using the ICD-10-CM.

Chapters 7 through 9 all have as their core the three cases. In these chapters, we ask readers to continue to apply their critical thinking skills to the information presented, skills that we believe are central to the competent practice of psychology. (More on the important issue of critical thinking momentarily.)

Chapter 7 examines how ethical issues are incorporated into professional practice. It begins with a general presentation on ethical standards and then considers the ethical issues raised by each of the three cases.

Chapter 8 presents a discussion of risk, that is, how one approaches clinical practice in a way that minimizes risk to the practitioner. Again, after some general comments about risk management, we consider the potential risks in each of the three cases, along with methods for minimizing those risks and thereby maximizing the positive outcomes for both patient and psychologist.

Chapter 9 covers disposition, that is, how one responds to a given case to reach whatever goals are set. With the first case, we present a possible treatment plan that could be developed, given the data available in that case. Case 2 is primarily an assessment case, but treatment issues are also examined. Case 3 is strictly an assessment case, so the focus of the discussion is on how to approach a case with such limits.

Chapter 10 is a snapshot of resources for the new psychologist. We have relied on many of these resources during our careers; many are classics with updated editions, and all are useful books or websites that exist to provide guidance in the practice of psychology. This chapter describes resources for the following areas, as well as a comment about additional resources: ICD, diagnosis, assessment, interviewing, practice guidelines, evidence-based practice, ethics, risk management.

Critical Thinking

We are certain that as you matriculated into your academic program, you heard comments from your faculty about the importance of critical thinking. But what is critical thinking?

The numerous definitions of *critical thinking* (Brookfield, 1987; Clayton, 2007; Facione, 2013; Scriven & Paul, 1987) all stress the need for the thinker (i.e., you) not to take things at face value but to examine systematically and thoroughly all of the information you have, challenge your conceptualizations of this information, and then draw conclusions in a self-disciplined and self-examining manner. We discuss this process and additional reasons for using critical thinking throughout this text.

Clearly, critical thinking is essential to the practice of psychology, as the Association of State and Provincial Psychology Boards (ASPPB) has incorporated this concept into its framework of Competencies Expected of Psychologists at the Point of Licensure (ASPPB, 2014a; Rodolfa et al., 2013). ASPPB lists three competencies that specifically include the concepts of critical thinking specific to the practice of psychology:

1. Select relevant research literature and critically review its assumptions, conceptualization, methodology, interpretation, and generalizability.
2. Interpret, evaluate, and integrate results of data-collection activities within the context of scientific/professional knowledge to formulate and reformulate working hypotheses, conceptualizations, and recommendations.
3. Articulate a rationale for decisions and psychological services that rely on objective supporting data (e.g., research results, base rates, epidemiological data).

You will see, as you move through the process to become a licensed psychologist, that licensing boards will require that you are able to think critically about your work as a psychologist. It is also important to note that the academic associations in psychology have worked together to develop models of competency, as well as the entity in psychology that accredits training programs. All of these competency models acknowledge the importance of critical thinking in the development of psychological competencies and the functioning of the psychologist.

As you can see from this discussion, we believe, and the profession emphasizes, that critical thinking is essential to the work of a psychologist. This book is written to help you do just that.

What's in a Name?

Before we conclude this chapter, we believe it is important to briefly discuss three issues. The first is our choice to use the term *patients* instead of *clients*. Psychology does not have a universally accepted term to refer to the individuals to whom we provide psychological services. *Patient* is the term most commonly used in medical settings, but it has the disadvantage of implying a hierarchical relationship. *Client* is the term most used in university counseling clinics, but it comes originally from business settings and has the disadvantage of implying a professional relationship in which the therapist provides information and advice as an accountant or attorney might, rather than a caring relationship in which the therapist treats mental disorders. We do not have an ideal term for a person with some psychological issues who is looking for a provider with expertise in listening and helping the person explore various behavioral and cognitive options, as well as teaching the person new behavioral and cognitive skills to treat psychological problems. As a result, we have chosen to use the term *patient*, partly because this text focuses on the issue of clinical assessment and diagnosis, and partly because we believe the term *patient* more accurately captures the relationship between psychologist and the individual seeking service. But it was a close call. We do, however, use the term *client* to refer to recipients of psychological services who are not individuals, such as couples, families, or organizations.

The second issue is how a patient is addressed, that is, by first name or more formally. We have chosen to refer to Lynn (Case 1; see Chapter 4) by her first name and John Smith (Case 2; see Chapter 5) and Anne Sanchez (Case 3; see Chapter 6) more formally, for several reasons. First, which form of address is most appropriate is in part a function of setting. The case of Lynn came from a university setting where most of the recipients of psychological services are students and typically they are addressed by their first name and use of a more formal address would seem awkward, at best, and distancing, at worst.

In other settings, such as medical or forensic settings, from which Cases 2 and 3 come, the use of formal address is much more common. In addition, in medical settings, most physicians and psychologists are referred to only as “Dr.” For a medical or psychological provider in turn to refer to his or her patient by first name appears to us to be disrespectful, as it stresses the inequality of the relationship. When discussing the case of Anne Sanchez, we also use a more formal address due to the setting and referral source, an attorney, where formality also helps define the nature of the professional relationship and boundaries.

We are raising this issue and suggesting that the use of address is important because it has to do with the context and the nature of the professional relationship. How you address your patients should be

carefully considered and discussed directly with them. We chose to use both means of address to raise this issue and indicate that both should be considered.

Third, throughout this book, we use the terms *diagnosis* and *assessment* repeatedly. Although similar, they are not the same thing. *Diagnosis* has to do with choosing a specific category to apply to a person. In this text, we use the ICD-10-CM classification system for that purpose. An *assessment* is the process of understanding the issues and problems of the person in the role of patient. One uses the assessment process to arrive at a diagnosis, and vice versa. This distinction is discussed in more detail in Chapters 2 and 3.

A further distinction relevant to our book is that between descriptive and dynamic diagnosis (Oyeboode, 2008). *Descriptive* diagnosis, the approach used by the ICD-10-CM, focuses on a statement of what is, that is, classifies individuals on the basis of the signs and symptoms they presented, that is, the behaviors, cognitions, and emotions present in the person. *Dynamic* diagnosis attempts to explain why those symptoms are present, usually using a behavioral, cognitive, or affective theory to explain the underlying causes of the symptoms. In this book, we attempt to describe rather than explain—that is, we describe the processes necessary to understand who the patient is; what experiences, objective and subjective, the person has; how the person presents to others; and whether those experiences and behaviors are in some way abnormal. We do not try to explain the underlying causes of such behaviors. That would be a different task for a different text.

In closing, we hope that this text contributes to your understanding of the ICD-10-CM; enhances your ability to assess, diagnose, and consider dispositions for your patients; enriches your capacity to think like a psychologist; and provide you a foundation to take the next step and put your knowledge into practice under close supervision.

Note to Instructors

This book is intended primarily for use in graduate training, in particular, in courses on assessment and psychopathology. It focuses on the issues involved in engaging in a process of psychological assessment, and it describes how one can use a diagnostic system, such as the ICD-10-CM, to arrive at a better diagnostic understanding of the patient, hence its usefulness in a course on psychopathology. We are in the process of developing a casebook as a companion text, which is included in the APA series on the ICD-10-CM. This casebook will help students examine 16 diagnostic categories using the framework provided in this current text. We anticipate that it will be available in 2016.