A Picture Is Worth a 1000 Words: Graphics to Explain ICD-10
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Diagnosis is about the recognition of patterns and the placement of those patterns into the recognized classes and actual disorders that have been provided in DSM-5 and now ICD-10. A comparative framework is offered using graphics of these categories and diagnoses that provides much information about related underlying clinical issues involved in the individual diagnoses and their treatments. Stepping back from the specifics of the diagnoses to examine the larger framework might allow for clarity to emerge.

The first level of stepping back is suggested by the meta-structure of the DSM-5. The classes of disorders unfold along a pattern of diagnoses with comparable severity, features, and courses being placed continguously; schizophrenia and psychotic disorders are located next to bipolar disorders; bipolar disorders are next to depressive disorders, which are contiguous with anxiety disorders (another affect); several groupings of diagnoses with anxious features follow anxiety disorder categories concluding with a somatic and other body disorders where the anxious feature may not be as clearly expressed by the clients. The section that seems out of place is Disruptive, Impulse-control, and Conduct Disorders--it suggest it follow after the other neurodevelopmental disorders where the symptoms and issues of the developing person is considered in the forefront of the discussion. Substance and personality disorders might be considered in a separate class from these other disorders but can be present in almost all of them.

The suggested graphics build on this overarching structure but also acknowledges points where the diagnoses touch each other and might be similar in details but provide a different process. It allows the clinician to relax and view the client's situation holistically. Symptoms can be prioritized in terms of persistence and impact and related to the overall disorder classes. If manic episodes are relatively persistent and delusions intermittent, some form of bipolar disorder with psychosis makes more sense than any type of schizophrenia with mania. If the client's presentation were the other way round, relatively persistent delusions with intermittent mania, then schizophrenia with mania makes more sense. The 30,000 foot view might be clarifying.

Approximately one-third of DSM-5 is dedicated to disorders that have a relationship to anxiety. Anxiety-based disorders and obsessive-compulsive disorders have clear anxiety issues embedded in them. Trauma-based and somatic disorders often have anxiety issues that are not obvious present at some level and might be more included with the more obvious disorders. At the same time the classes of disorders and their anxieties work differently. The thoughts and behaviors of obsessive-compulsive disorders are qualitatively different from phobias, which are also very different from the anxieties coming from traumatic etiologies. Most bodily dysfunctions, when not directly related to depression or some other disorder, could have anxiety involved in its process—certainly most sexual issues seem to work that way. A graphic separating these classes of diagnoses might offer clarification to the similarities and differences among these anxiety-based disorders.

Because of the importance that comes with the power to wield these diagnoses, having another perspective to examine the diagnostic choices that are being made might be useful and limit doing no harm to clients.

Recommendations for Counselors

References