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Article: Differential diagnosis: Figuring out What is Going on with Clients

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I have been trained in Jungian therapy, cognitive and behavioural therapies, non-directive counselling, play and expressive arts therapy, hypnosis, group therapy, and family therapy[1]. Each school or modality takes a different approach to formulating problems and working toward solutions and healing. Whatever theoretical orientation we might use in our work, the art of differential diagnosis is a critical component of our work, and I would argue that it is necessary for success with clients. It provides us with a mental roadmap.

In my experience, when clients are not improving in treatment, it often means that something important has been missed with the clinical formulation. I have never regretted conducting a thorough intake assessment, but I have almost uniformly regretted not having conducted a thorough enough initial evaluation, even when clients are coming for short-term therapy. The only exception is when we use a single-session consultation model, where clients come with a specific concern they wish to address, such as test anxiety. In these cases, I always advise them that their ability to benefit from treatment may be impeded by underlying conditions or factors that we have not taken the time to consider. A superficial evaluation can hamstring our efforts.

The act of diagnosis requires several steps: **1)** considering possible diagnoses *(i.e., explanations),* **2)** ruling out certain diagnoses, and **3)** ruling in other diagnoses. The first step requires us to cast a wide net. The second requires us to actively look for evidence *against* a condition. The third requires us to actively look for evidence in support of a condition. The operational space where we do this mental work is called the *differential*. It is where we differentiate diagnostic formulations with a specific client or clients (such as a couple).

The art of differential diagnosis is relevant for all theoretical systems, but is best understood when applied to a clearly delineated diagnostic system such as the Diagnostic and Statistical Manual of Mental Disorders – 5th Edition (DSM-5) or the International Classification of Disease – 10th Edition (ICD-10). These systems have carefully categorized diagnostic entities under groupings such as: anxiety, mood, neurodevelopmental, impulse-control, sleep, trauma, etc. While the DSM system articulates specific diagnostic criteria to help facilitate the process (i.e., symptoms, behaviours, clusters, timelines, and impairments), ICD relies on a more holistic appreciation of what a particular condition looks like in a *typical manifestation*. Family therapy expressly aims to understand the broader context of familial and social dynamics and their impact on individuals while frameworks that hyper-emphasize the psychology of the individual (such as the DSM), still require consideration of cultural and societal factors.

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[1] When I state that I have been trained in an area, this means that I have taken at least one graduate course or equivalent in theoretical training and received at least 100 direct hours of supervision, and a minimum of 400 hours of applied experience.

When we engage in differential diagnosis, it is important to follow some tried and true procedures. I suggest the following six to guide your work.

First, we should consider all possibilities. *A missed diagnosis could be as detrimental as a mis-diagnosis.* When you see your family physician about a sore throat, you don't want your GP to assume that you have a virus or cold based on statistical probabilities. You want your GP to examine you, to consider all reasonably possible explanations, and to collect enough information to be confident you do indeed have a cold and not throat cancer or a streptococcal infection. This means that we should actively screen for all possible explanations. I personally screen for every possible condition in our diagnostic manual to help ensure that I do not miss something important. This wide-angle framework also requires us to consider socio-cultural factors, the influence of medications and substances, and the potential impact of medical conditions. As we engage in this process, we should be on the lookout for comorbid conditions (ones that hang out together such as ADHD with autism) and secondary conditions (ones that are created and maintained by the initial condition such as anxiety associated with a learning disability).

Second, we should take a lifetime perspective (i.e., movie) rather than a current perspective (i.e., snapshot). *If our work is too "here-and-now" focused without considering the "there-and-then," we could easily miss the mark.* A current-symptom perspective might lead us to conclude that an individual has subthreshold depression symptoms. Meanwhile, a lifetime-symptom perspective might help us to see that the individual has experienced a recurrent depressive disorder over many years that was worse several months before they saw you and has improved so that the current presentation is actually *"in partial remission."* A subthreshold depression is very different than a recurrent depression.

Third, we should never treat diagnostic criteria as a simple checklist. *The most lazy and dangerous approach to diagnosis is to treat diagnostic criteria like a checklist.* The presence of a specific symptom or criterion tells us nothing about its root cause – the driving force behind it. Try to imagine all of the possible explanations for somebody experiencing insomnia: anxiety, depression, PTSD, sleep apnea, ADHD, a noisy house, blue light exposure, alcohol or opioid withdrawal, mania… The list goes on. For every symptom the client endorses, we need to understand its causes.

Fourth, we should always consider the parameters of any particular symptom or syndrome. This includes the frequency, severity, duration, onset and offset patterns, as well as facilitative and exacerbating factors (what makes it better or worse). These considerations help us to understand the client's symptoms *in situ*, which can facilitate decision-making.

Fifth, we should always consider impairments in functioning that result from the symptoms, syndromes, or conditions. *The presence of symptoms without obvious impairment usually equates to no diagnosis.* For example, I may be terrified of snakes, but if I don't encounter them in my daily life, I can't be diagnosed with a phobia. A few conditions like Tourette's can be diagnosed without impairments, but most do require this criterion. Importantly, for many clients, impairments are more concerning than specific symptoms, and need to be considered in treatment. Additionally, many treatment funders

(WCB, MVA insurance) will only support treatment if there is impairment or some kind of limitation in functioning, which must be documented.

Finally, when we do our work, we should always be open to the possibility that we were wrong, or that the client's condition has changed. I made this mistake early in my career when I diagnosed and treated depression in a teenage girl. What I missed was another underlying condition that was likely a contributor to her depression, or even the sole cause of it. As her depression cleared, her ADHD (inattentive) became more apparent. However, since I was focused on her depression symptoms, I wasn't considering anything else. The pediatrician caught it. And I learned my lesson. Always have an open mind.