The Removal of the Multiaxial System in the *DSM-5*: Implications and Practice Suggestions for Counselors

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With the advent of the *DSM-5* in 2013, the American Psychiatric Association eliminated the longstanding multiaxial system for mental disorders. The removal of the multiaxial system has implications for counselors' diagnostic practices. In this article, the removal of the multiaxial system in the *DSM-5* is discussed, and counselor practice suggestions related to each of the five Axes are provided. Additionally, ways in which counselors can sustain their current diagnostic skills while developing updated practices that align with the new streamlined system will be discussed.

Keywords: DSM-5, **multiaxial system, diagnostic skills, mental disorders**

The American Psychiatric Association (APA) developed the original *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1952 to create a uniform way to define mental health disorders. At the time, the manual contained narrative, psychodynamic descriptions regarding psychiatric disorders. Fueled by criticism regarding questionable foundations and lack of discrete diagnostic criteria, APA engaged in a comprehensive overhaul of the diagnostic system in preparation for the third edition of the manual (First, 2010). In 1980, the APA released the radically different *DSM-III*, a categorical nosological system with presumably atheoretical foundations and a multiaxial assessment system that ensured attention to biological, psychological and social elements related to mental disorders.

Although paradigm shifts were not as comprehensive as some might have hoped (First, 2010; Kupfer & Reiger, 2011), the most recent revision process resulted in the *DSM-5* (APA, 2013) and the first major structural changes to diagnostic classifications and procedures since the *DSM-III* (APA, 1980). Key *DSM-5* changes included reorganization of disorders into new categories on the basis of presumed etiological characteristics, movement toward dimensional conceptualization of disorders and discontinuation of the multiaxial system (Dailey, Gill, Karl, & Barrio Minton, 2014). Some revisions, such as a trend toward lower diagnostic thresholds (Frances, 2013; Miller & Prosek, 2013) and incorporation of complex, unvalidated assessment tools (First, 2010; Jones, 2012) received a great deal of public attention and comment. In contrast, removal of the multiaxial system happened quietly and with very little scholarly or public comment (Probst, 2014).

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In this article, the title *DSM* will be used to refer to historic versions of the *Diagnostic and Statistical Manual of Mental Disorders*. References to specific editions will be clearly indicated with numerals or numbers in addition to the title. First, we provide a brief overview of the *DSM* and its use by counselors. Next, we describe the longstanding multiaxial system and discuss arguments in favor of and against removal of the multiaxial system. Throughout, we discuss implications for counselor diagnosis and practice.

Counselors' Use of the *DSM*

In order to understand the implications of the elimination of the multiaxial system, professional counselors must possess a preliminary understanding of the complex relationship between professional counseling and the *DSM*. Over time, the more general *DSM* system has come under critical review, especially by counselors who question how the diagnostic process fits with our professional identity and ethical obligations (Eriksen & Kress, 2006; Kress, Hoffman, & Eriksen, 2010; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). Eriksen and Kress (2005) detailed commonly cited limitations of the *DSM* and how it is used:

- Historically, some diagnostic labels have marginalized, stigmatized and harmed those who are different from the mainstream (e.g., homosexuality was once a *DSM* diagnosis).
- There is limited evidence of cross-cultural validity in diagnostic conceptualizations.
- Counselors who focus narrowly on diagnosis may only look for behaviors that fit within a medical or biological understanding of the person's struggles (i.e., becoming reductionistic).
- The *DSM* system does not include sufficient emphasis on contextual factors (e.g., developmental struggles and transitions, culture, gender), strengths, resources, and uniqueness that may better explain the roots of client struggles and treatment implications.
- The *DSM* system cannot predict treatment outcomes or point to the etiology of mental disorders.
- Some people may use diagnosis to accept a self-fulfilling prophecy that their situation is hopeless and that they are sick.
- Diagnosing may preclude a focus on the client's unique construction of his or her experience.
- There are flaws in the science behind *DSM* diagnoses; what is and is not classified as a mental disorder is often rooted in a political agenda and historical influences.

Limitations of the *DSM* require that counselors use it carefully, and thoughtfully consider challenges related to its use. Although Eriksen and Kress (2005) wrote in reference to the *DSM-IV-TR,* underlying assumptions and broad-based diagnostic processes have not changed in the *DSM-5* (APA, 2013). We expect that these limitations will continue to be relevant to counselors.

In contrast to the reductionistic, medically oriented diagnostic model inherent within the *DSM* system (Eriksen & Kress, 2005), counselors emphasize strength-based and developmentally, culturally and contextually sensitive approaches (Kress & Paylo, 2014). Despite the best efforts of many counselors to establish and promote a professional identity that is distinct from other mental health professions, market demands frequently dictate aspects of clinical practice (Eriksen & Kress, 2006). Counselors are licensure-eligible in all 50 states and regularly recognized on insurance panels; as such, there is an expectation that mental health counselors will use the *DSM* for third-party reimbursement (Kress & Paylo, 2014). Thus, counselors may find themselves working to balance unique professional identities with realities of a diagnostic system created by and for physicians who have a primary focus on pathology.

Despite its limitations, the *DSM* system is useful in a number of ways (APA, 2013; Dailey et al., 2014; Eriksen & Kress, 2005, 2006; Kress & Paylo, 2014). Primarily, it serves as a way of communicating about client problems and struggles. Assuming that all client-related information is considered, it offers a vehicle for

reducing complex information into a manageable form (Kress & Paylo, 2014). Through the categorization of psychological symptoms into disorders, the *DSM* system provides a means for counselors to select evidence-based treatments that correspond to said disorder. Some clients may benefit from receiving a diagnosis as it may help them to normalize and understand their experiences, sometimes even helping them to reduce the shame and self-blame that often relate to symptoms (Eriksen & Kress, 2005). Finally, categorization and identification of disorders allows researchers to study the etiology and treatment of various mental disorders. Such a process lends itself well to the development of prevention, early intervention and effective treatment measures that have very real impacts on clients' lives (APA, 2013). The *DSM-5* (APA, 2013) also provides systematic information about diagnostic features, associated features supporting diagnosis, subtypes and/or specifiers, prevalence, development and course, risk and prognostic factors, diagnostic measures, functional consequences, culture-related diagnostic issues of each diagnosis; this information may be helpful to counselors who are struggling to fully understand their clients' experiences.

An understanding of clients' contextual experience is essential for conceptualizing client concerns and planning counseling strategies that are relevant to clients and have a strong probability of success (Kress & Paylo, 2014). In the past, those who engaged in multiaxial diagnosis were cued to at least consider biopsychosocial elements of clients' concerns, including mental disorders, medical conditions, psychosocial and environmental stressors, and overall functioning. In the following section, we attend to the rise and fall of the multiaxial system.

Rise and Fall of the Multiaxial System

The APA first introduced the multiaxial system in the *DSM-III* (1980). A radical departure from the previous version of the document, the *DSM-III* introduced categorical, symptom-based diagnosis (First, 2010). In attempts to ensure clinical utility of information reported, the authors suggested, but did not require, that clinicians report diagnostic information on five distinct Axes. This tradition continued with only modest changes in the *DSM-IV* (APA, 1994) and *DSM-IV-TR* (APA, 2000).

The *DSM-IV-TR* (APA, 2000) multiaxial system involved documentation of diagnosis on five Axes. Axis I listed the primary or principal diagnoses that needed immediate attention; this included recording of clinical disorders as well as "Other Conditions That May Be a Focus of Clinical Attention" (e.g., life stressors, impairments in functioning; APA, 2000, p. 27). Axis II contained pervasive psychological issues such as personality disorders, personality traits and mental retardation (now intellectual disability disorder) that shaped responses to Axis I disorders. Axis III was intended to cue reporting of medical or neurological problems that were relevant to the individual's current or past psychiatric problems. Axis IV required clinicians to indicate which of nine categories of psychosocial or environmental stressors influenced client conceptualization or care (e.g., recent divorce, death of partner, job loss). Finally, Axis V included the opportunity to provide a Global Assessment of Functioning (GAF) rating, a number between 0 and 100 intended to indicate overall level of distress or impairment.

Introduction of the multiaxial system was never without controversy or difficulty (Probst, 2014). Specific concerns included the degree to which Axes I and II were mutually exclusive and distinct (Røysamb et al., 2011), lack of clear boundaries between medical and mental health disorders (APA, 2013), inconsistent use of Axis IV for clinical and research purposes (Probst, 2014), and poor psychometric properties and clinical utility of the GAF (Aas, 2010; APA, 2013). Those most closely associated with APA noted concern that the multiaxial system was rarely used to its full potential and lacked clinical utility (APA, 2013; First, 2010). In 2004, APA first entertained a motion to explore elimination of the multiaxial system unless evidence was presented to suggest that the system enhanced patient care (First, 2010; Probst, 2014). Upon reviewing the literature, a 2005

committee recommended maintaining the system in the next iteration of the *DSM* and suggested that APA provide resources to support more widespread and consistent use (Probst, 2014). Nearly eight years later, the APA discontinued use of the multiaxial system, seemingly without public discussion or comment. Indeed, APA included just three paragraphs regarding this shift in the *DSM-5*, noting that "despite widespread use and its adoption by certain insurance and governmental agencies, the multiaxial system in DSM-IV was not required to make a mental disorder diagnosis" (2013, p. 16).

From Multiaxial to Nonaxial Assessment

Clinicians who are accustomed to documenting diagnosis using a multiaxial system may wonder what *DSM-5* assessment and diagnosis will look like. APA provided little concrete guidance, stating, "DSM-5 has moved to a nonaxial documentation of diagnosis (formerly Axes I, II and III), with separate notations for important psychosocial and contextual factors (formerly Axis IV) and disability (formerly Axis V)" (2013, p. 16). In the following sections, we explore evidence related to the shift and identify implications for counselors.

Medical and Mental Health Conditions (Axes I, II and III)

Axes I, II and III have been eliminated in the *DSM-5* (APA, 2013). Clinicians can simply list any disorders or conditions previously coded on these three Axes together and in order of clinical priority or focus (APA, 2013). Because many billing systems already used this system, this may not result in meaningful changes in terms of third-party billing.

This change removes the distinction of previous clinical disorders, personality disorders and intellectual disability disorder. Over time, clinicians have questioned whether Axis II personality disorders were qualitatively different from or any more stable than Axis I clinical disorders (Røysamb et al., 2011); one might also argue that certain developmental disorders (e.g., autism spectrum disorder, previously coded on Axis I) are just as longstanding and pervasive as intellectual disability disorder. Although there is some evidence that personality disorders are distinct from other clinical disorders, emerging evidence indicates that mental disorders do not factor cleanly into these classifications (Røysamb et al., 2011). It is possible that this subtle shift in coding may decrease the stigma often associated with personality disorders.

At the same time, this change in coding suggests that there is no differentiation between medical conditions and mental health disorders. Initially, APA released a definition in which it conceptualized mental disorders as "a behavioral or psychological syndrome or pattern that occurs in an individual" and "reflects an *underlying psychobiological dysfunction* [emphasis added]" (APA, 2012). The resulting controversy and dialogue regarding lack of evidence for the claim led to a more balanced definition of mental disorder as involving "a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (APA, 2013, p. 20). Still, clinicians will find that the previous *DSM-IV-TR* phrase "general medical condition" has been replaced with "another medical condition" throughout the *DSM-5* (e.g., APA, 2013, p. 161). Together, these reinforce an assumption that mental disorders are rooted in biological causes.

Some have suggested that an increased emphasis on mental disorders as organic implies that environmental factors are less important, and this could reduce the stigma that many people with mental disorders feel (Yang, Wonpat-Borja, Opler, & Corcoran, 2010). Certainly, the *DSM-5* (APA, 2013) includes evidence that some mental disorders have considerable genetic and neurological links, even if scientists have yet to identify clear laboratory markers for any *DSM* diagnosis (First, 2010). However, others have suggested that this approach could reinforce the notion that those with mental disorders are biologically flawed as opposed to being complex beings who traverse many complicated contextual factors that impact their functioning (Ben-Zeev, Young, & Corrigan, 2010).

This shift toward viewing mental disorders from a neurobiologically based perspective may result in increased use of psychopharmacotherapy, or medication therapy (Frances, 2013). Although many clients may benefit from or require psychotropic medications to function effectively, others with mental disorders do not require this type of intervention. The use of medications can invite serious side effects and financial costs and preclude participation in psychosocial therapies demonstrated to be successful in long-term management of many mental disorders. Counselors should be mindful of these changes as they advocate at the community, state and national levels to ensure clients are educated about medication options, understand effectiveness of psychosocial and counseling treatments, and have access to appropriate care (Dailey et al., 2014).

Even if somewhat arbitrary, removing the distinction between mental disorders and medical disorders has the potential of creating confusion within the helping professions as to the nature of the treatment provided. Counselors may struggle regarding their role in recording medical diagnoses that they are not qualified to diagnose, and should collaborate with medical professionals to offer a holistic treatment conceptualization. Counselors would do well to consider the body of evidence regarding etiology of mental disorders and evaluate ways in which they may make unique contributions to client change.

Psychosocial and Contextual Factors (Axis IV)

Clinicians previously listed psychosocial and contextual factors that affect clients and are relevant to conceptualization on Axis IV:

> Originally conceived in the third edition of the diagnostic manual as a way to rate and rank the severity of particular stressors, axis IV was simplified for the fourth edition because of the difficulty in reliably quantifying the etiologic contribution of specific stressors to mental disorder; instead, clinicians were asked to simply note salient environmental factors. (Probst, 2014, p. 123)

This included notation regarding concerns in nine key areas: primary support group, social environment, education, occupation, housing, economic, access to health care, legal system/crime and other (APA, 2000).

Although information listed on Axis IV was intended to supplement diagnoses on the first two Axes, clients who attended counseling for only an Axis IV diagnosis were not eligible to receive mental health coverage from insurance companies (APA, 2013). In fact, Probst (2014) provided evidence that APA was intentional in ensuring that Axis IV was not codable and optional for billing purposes in efforts to preserve a degree of client confidentiality. As such, the new nonaxial coding system might actually increase accessibility of services depending upon insurance companies' individual responses (APA, 2013). Beginning with the *DSM-5*, clinicians are advised to make a separate notation regarding contextual information, rather than including it in axial notation. However, the APA (2013) did not provide guidance regarding how or where to do so.

Although there is no longer an Axis for contextual factors, it is imperative that counselors maintain a holistic focus that aligns with our unique identity (Hansen, 2009). Along with a humanistic, strength- and competency-based perspective, counselors are sensitive to contextual and cultural considerations. Context refers to the interrelated conditions in which clients' experiences occur, or any factors that surround their experience and illuminate their situation. As previously discussed, many traditional understandings of mental disorders highlight a pathology- and deficit-based perspective. When considering clients' situations from a contextual perspective, counselors are responsible for incorporating attention to culture, gender and various developmental factors. "Eliminating axis IV does not eliminate the need to consider context—unless it can be shown that genetic and neurochemical factors alone account for the emergence, variation, and trajectory of mental and emotional disorder" (Probst, 2014, p. 129). Thus, counselors are challenged to find new ways to communicate information previously provided in the multiaxial system.

A firm understanding of clients' context may lead to a more compassionate and holistic conceptualization of symptoms that could be better explained by contextual factors or environmental stressors (Eriksen & Kress, 2005; Kress & Paylo, 2014). In addition, epidemiological research suggests that psychosocial and environmental problems have moderate predictive value for understanding prognosis of major depression, suicidality, anxiety disorders and substance use disorders (Gilman et al., 2013). Additionally, contextually sensitive counselors define some mental disorders as being a person's functional attempts to adapt to or cope with a dysfunctional context (Ivey & Ivey, 1999). It is important that any diagnostic discussions integrate a focus on these contextual factors.

Culture is an exceptionally important contextual consideration; through culture, clients define, express and interpret their beliefs, values, customs and gender role expectations (Bhugra & Kalra, 2010). Multicultural considerations should enlighten counselors' diagnostic decisions and ultimately the treatment process. Although it still has room for development, the *DSM-5* (2013) includes systematic information regarding gender and culture for each diagnostic category. In some cases, this is limited to a simple accounting of the prevalence of disorders within certain groups; in other cases, APA provided information regarding the diverse presentation or understanding of disorders. Further, the American Counseling Association's (ACA) *Code of Ethics* (2014) emphasizes that culture influences manifestation and understanding of problems; thus, counselors must consider culture throughout the counseling and treatment process.

Counselors can use formal or informal assessment to explore and understand clients' context. The *DSM-5* includes a Cultural Formulation Interview (CFI) that counselors can use to help them understand clients' context and its impact on their experiences and symptoms. The CFI may help counselors obtain the most clinically useful information, develop a relational connection with clients and ultimately make accurate diagnoses. The CFI is included in Section III of the *DSM-5* and is a semi-structured interview composed of 16 questions that address both individual experience and social context. The text is divided into two columns, with counselor-generated questions on the right and instructions for application on the left. Two versions of the interview are available, one for the individual and one for an informant (e.g., a caregiver or a parent). The interviews also are available online at the APA's (2014) *DSM-5* website. The CFI also includes 12 Supplementary Modules, which provide additional questions used to assess domains of the 16-item CFI (e.g., cultural identity) as well as questions that counselors can ask during the cultural assessment of particular groups (e.g., children and adolescents, older adults, immigrants and refugees, and caregivers).

Should counselors elect not to use this more formal interview format to assess culture, there are multiple additional formal and informal cultural assessments as well as assessment guidelines that they can apply. For example, Castillo (1997) provided the following guidelines for culturally sensitive diagnosis: (a) assess the client's cultural identity; (b) identify sources of cultural information relevant to the client; (c) assess the cultural meaning of a client's problem and symptoms; (d) consider the impacts and effects of family, work and community on the complaint, including stigma and discrimination that may be associated with mental illness in the client's culture; (e) assess for counselor personal biases; and (f) plan treatment collaboratively. Castillo's guidelines offer a comprehensive assessment that may inform diagnostic practices.

The ACA's *Code of Ethics* (2014) also indicates that counselors should recognize social prejudices that lead to misdiagnosis and overpathologizing of certain populations. It is impossible to understand clients' unique situations and how to best help them if cultural considerations are not addressed. An understanding of clients' culture in relation to diagnosis includes understanding cultural explanations of their experiences, their help-seeking behavior, the cultural framework of clients' identity, cultural meanings of healthy functioning and cultural aspects that relate to the counselor–client relationship (Eriksen & Kress, 2005).

Counselors can address, consider and convey contextual factors through use of V Codes and Z Codes, and by including attention to contextual factors within the treatment record and conceptualization process (Kress, Paylo, Adamson, & Baltrinic, in press). In the *DSM-5*, the APA greatly expanded the list of codes to provide a means for documenting "other conditions and problems that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of a patient's mental disorder" (2013, p. 715). These are included alongside mental disorders and medical conditions on the nonaxial diagnosis discussed previously. Examples of V/Z Codes in the *DSM-5* include the following: difficulties rooted in interpersonal issues (e.g., parent–child, sibling, partner distress), issues with abuse and neglect (e.g., partner abuse, child abuse, maltreatment), education or occupational difficulties, problems with housing and finances, difficulties within their social environment (e.g., phase of life, acculturation, target of discrimination), legal issues and other personal circumstances (e.g., obesity, nonadherence to treatment, borderline intellectual functioning). For example, a client who presents with major depressive disorder and reports a recent marital separation that has resulted in homelessness might receive a diagnosis of: *296.22 (F32.1) major depressive disorder, single episode, moderate; V61.03 (Z63.5) disruption of family by separation*; and *V60.0 (Z59.0) homelessness*.

The move toward eliminating the multiaxial system emphasizes the idea that mental disorders do not occur apart from physical considerations and contextual struggles. In some ways, this change is consistent with a professional counseling philosophy. However, because there is no longer an infrastructure to cue consideration of contextual concerns, counselors must be ever more vigilant in identifying systematic ways to assess this information and integrate it into treatment plans in meaningful ways. How counselors convey this information may vary across providers and contribute to some confusion in communicating this information. Thus, the elimination of this axis may provide more flexibility at the expense of clear communication.

Functioning and Disability (Axis V)
Initially developed as the Health-Sickness Rating Scale, the GAF was introduced as Axis V of the *DSM-III* and *DSM-IV* (Aas, 2011). The scale called for clinicians to "consider psychological, social, and occupational functioning on a hypothetical continuum of mental health–illness. Do not include impairment in functioning due to physical (or environmental) limitations" (APA, 2000, p. 34). Over time, this single number scale came to be used to assist in payers' determinations of medical necessity for treatment and in determining eligibility for disability compensation (Kress & Paylo, 2014). The APA discontinued use of the GAF in the *DSM-5*, and now suggests that clinicians use the World Health Organization Disability Assessment Schedule (WHODAS 2.0) as a measure of disability.

The GAF scale was removed from the *DSM-5* because of perceived lack of reliability and poor clinical utility (APA, 2013). In a comprehensive review of literature regarding the GAF, Aas (2010, 2011) concluded insufficient reliability in clinical settings, lack of precision, inability to detect change and limited evidence of concurrent and predictive ability. One additional concern is the way in which the GAF combined attention to symptom severity and impairment. Hilsenroth et al. (2000) noted concern regarding overlap between previous Axis I and II diagnoses and GAF ratings, as evidenced by the APA's continuing work to develop alternate measures of functioning such as the Global Assessment of Relational Functioning and the Social and Occupational Assessment Scale. Empirical evidence suggested that GAF scores relate to client and clinician perceptions of concerns (Bacon, Collins, & Plake, 2002; Hilsenroth et al., 2000) more so than with social adjustment or interpersonal problems (Hilsenroth et al., 2000). Others have expressed concern regarding the limits of use of the GAF with children (Schorre & Vandvik, 2004).

Ro and Clark (2009) argued that the construct of functioning is complex and multidimensional in a way that simple GAF ratings regarding symptom severity and impairment cannot capture. They stated that the World Health Organization's (WHO) conceptualization of functioning as a component of health, and disability

as impairment in functioning, was particularly helpful. Perhaps more importantly, Ro and Clark presented empirical evidence that functioning includes four key factors: well-being (including satisfaction, quality of life and personal growth), basic functioning in life demands, self-mastery, and interpersonal and social relationships. Certainly, this conceptualization fits well with an understanding of counseling as a profession dedicated to maximizing human development (Hansen, 2009).

Historically, payers approved the nature and extent of services based upon GAF scores, diagnosis, severity of symptoms, danger to self or others, and disability across life contexts. With the elimination of the multiaxial system, counselors will no longer note a GAF score, and will not have an assessment of functioning built into the documentation process. In the absence of GAF scores, the APA (2013) suggested that practitioners use alternative ways to note and quantify distress and disability in functioning. The APA also suggested that practitioners continue to assess for suicide and homicide risk and use available standardized assessments to assess for symptom severity and disability (APA, 2013).

The APA (2013) recommended the WHODAS 2.0 as a preferred measure for use in assessing clients' functioning. The WHODAS 2.0 can be used with clients who have a mental or physical condition or disorder. The WHODAS 2.0 is a free assessment instrument that is provided in the *DSM-5*, included on the WHO's website and available through the *DSM-5* online assessment measures website (www.psychiatry.org/dsm5). A manual (Üstün, Kostanjsek, Chatterji, & Rehm, 2010) also is available free of charge.

The WHODAS 2.0 is a 36-item measure that assesses disability in people 18 years and older. It assesses for disability across six different domains: self-care, getting around, understanding and communicating, getting along with people, life activities (e.g., work and/or school activities), and participation in one's community/society. When completing the form, clients rate the six areas based on their functioning over the past 30 days. Respondents are asked to respond as follows: none (1 point), mild (2 points), moderate (3 points), severe (4 points), and extreme or cannot do (5 points). Scoring of the assessment measure involves either simple scoring (i.e., the scores are added up based on the items endorsed with a maximum possible score suggesting extreme disability as 180) or complex scoring (i.e., different items are weighted differently). The computer program that provides complex scoring can be found on the WHO's website. The WHODAS 2.0 can be used to track changes in the client's level of disability over time. It can be administered at specified intervals that are most relevant to the clients' and counselors' needs.

The WHODAS 2.0 has been decades in development, involving more than 65,000 participants in hundreds of studies conducted across 19 countries. Üstün et al. (2010) summarized psychometric evidence in support of the WHODAS as follows:

> The WHODAS 2.0 was found to have high internal consistency (Cronbach's alpha, α: 0.86), a stable factor structure; high test-retest reliability (intraclass correlation coefficient: 0.98); good concurrent validity in patient classification when compared with other recognized disability measurement instruments; conformity to Rasch scaling properties across populations, and good responsiveness (i.e., sensitivity to change). Effect sizes ranged from 0.44 to 1.38 for different health interventions targeting various health conditions. (p. 815)

The authors concluded that the instrument is robust and easy to use. Likewise, the assessment tool was tested in the *DSM-5* field trials, and researchers suggested that it was sound and reliable in routine clinical evaluations (APA, 2013). Despite strong validity evidence, Kulnik and Nikoletou (2014) cautioned that the instrument seems to connect most cleanly to medical or physical elements of disability, sometimes at the expense of social

aspects of disability. Similarly, the WHODAS 2.0 only assesses one of four areas of functioning identified by Ro and Clark (2009). Although counselors may find the WHODAS 2.0 helpful for understanding some elements of disability, they may do well to consider additional holistic and comprehensive opportunities to assess client functioning and strengths.

Discussion

Counselors should be aware that the act of rendering a *DSM* diagnosis is only one part of a comprehensive assessment. What one reports in terms of diagnosis is just a snapshot of the client. It does not capture the totality of one's understanding regarding client strengths and limitations, nor does it indicate how counselors go about constructing that understanding. Any thorough assessment must take into account an understanding of all relevant factors. These include, but are not limited to, psychosocial factors such as psychological symptoms, family interactions, developmental factors, contextual factors, functional abilities and longitudinal-historical information.

Given elimination of the multiaxial system, we advise counselors to be especially alert to listing V or Z Codes as part of the diagnosis in order to maintain consideration for client context in addition to biology and symptomology. As with prior editions of the *DSM,* counselors can still use V or Z Codes as sole diagnoses or to augment other diagnoses. Counselors also should document contextual information in their records so that this information can be conveyed to others as appropriate and used to support clients' treatment.

There are a number of models that can be used to guide counselors' diagnostic, case conceptualization and treatment practices. One such model is the I CAN START model (Kress & Paylo, 2014), which follows:

- I (Individual) represents the individual counselor and his or her unique experiences, competencies, limitations and other personal factors;
- C (Context) relates to an understanding of the client's unique context (e.g., culture, gender, sexual orientation, developmental level, religion/spirituality);
- A (Assessment and Diagnosis) represents the assessment of the client and his or her symptoms and the accompanying *DSM-5* diagnosis;
- N (Necessary level of care) refers to the client's required level of care (e.g., residential treatment, hospitalization, outpatient treatment, individual counseling, family therapy);
- S (Strengths) signifies the client's strengths, resources, and capacities, which can be used in treatment to help him or her overcome his or her problems and thrive;
- T (Treatment) represents the utilization of an evidence-based treatment in addressing the presenting disorders or problems;
- A (Aims and objectives of treatment) denotes the development of clearly defined problems, with measurable goals and clear behavioral counseling objectives;
- R (Research-based interventions) refers to the use of counseling techniques that are based on research; and
- T (Therapeutic support services) involves the use of support services that may complement counseling interventions and treatments (e.g., case management, medication management, nutrition counseling, a physical exercise program, parent training, yoga, meditation).

The loss of the multiaxial system in the *DSM-5* provides both opportunities and challenges to counselors. The exact outcome of how the new process will be implemented is not yet known, and only time will show the extent of its impact. With the loss of the multiaxial system, some of the structure associated with its use is also

lost. Moving forward, counselors should continue to develop methods for assessing and documenting aspects of the multiaxial system that have been eliminated. With this change comes an opportunity to reaffirm holistic and integrated views of clients and to provide leadership for other mental health professions and professionals regarding how to incorporate this perspective into diagnostic practices.

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