Revising Diagnoses for Clients with Chronic Mental Health Issues: Implications of the *DSM-5*

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Major depressive disorder, bipolar I disorder and schizophrenia are chronic conditions, and adults who have these diagnoses often benefit from mental health treatment throughout their lives. The recent fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) included changes to many diagnoses. Consequently, counselors need to understand the changes and revise their diagnostic practices accordingly. Changes affect new clients being diagnosed for the first time as well as long-term clients who were initially diagnosed many years ago. This manuscript provides an explanation of changes to major depressive disorder, bipolar I disorder and schizophrenia. Case examples illustrate implications for counselors who work with clients who have these three serious and chronic mental illnesses. Counselors, following best practice guidelines and the American Counseling Association's ethical mandate, can take advantage of this opportunity to ensure that clients understand their mental health conditions and that documented diagnoses are accurate and thorough.

Keywords: **major depressive disorder, bipolar I disorder, schizophrenia, *DSM-5*, diagnoses, chronic mental illness**

Major depressive disorder, bipolar I disorder and schizophrenia are chronic mental health conditions. Adults who have these diagnoses often benefit from mental health treatment from counselors, psychiatrists and other clinicians throughout their lives. A new edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013) has been released. The changes therein impact both new clients who present for initial assessment and also clients who have been in treatment for chronic conditions. A thorough understanding of the implications for revising existing diagnoses will help counselors provide quality services to clients who need ongoing support. Counselors also are responsible for helping clients understand their diagnoses, so the release of the *DSM-5* is an opportunity to ensure that both new clients and clients in long-term treatment have an opportunity to ask questions about their conditions (American Counseling Association [ACA], 2014). Using the full terminology available in the *DSM-5* (e.g., defined diagnoses instead of *other specified* umbrella diagnoses and including specifiers to highlight key features of the disorder) will help establish the new common language so that clinicians and clients can all communicate effectively about treatment. To illustrate how counselors can use the *DSM-5* to best serve clients who have major depressive disorder, bipolar I disorder and schizophrenia, this article provides information about each disorder, a description of the changes from the *DSM-IV-TR* to the *DSM-5*, case examples and conclusions.

Major Depressive Disorder

Nearly 16 million adults in the United States experience a major depressive episode each year (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013), as defined by the *DSM-IV-TR* (APA, 2000). Individuals who experience major depressive disorder suffer from impairment in every part of their lives,

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including relationships, functioning at work and self-care. When symptoms of depression increase, individuals may not feel motivated to spend time with others. They may feel no pleasure in previously enjoyable activities and experience interactions with others as draining. Similarly, a previously motivated and engaged employee may seem distracted or disconnected at work and absenteeism may become a problem. In addition to problems in relationships and at work, self-care also is impacted by major depression. Time and energy for healthy habits such as exercise and meal preparation may be lost. In severe cases, a lack of attention to basic hygiene may be observable.

The severity and length of symptoms can vary tremendously for individuals with major depressive disorder. Some people never experience remission while others may enjoy years without symptoms (National Institute of Mental Health [NIMH], n.d.-a). The longer the period of remission, the lower the likelihood of a recurrence (APA, 2013). For those individuals who have more severe episodes, a history of multiple previous episodes, or were first diagnosed at a younger age, lifelong mental health treatment may be necessary to increase quality of life (APA, 2013).

Treatment. Almost 11 million people diagnosed with major depressive disorder sought treatment in 2012, which was approximately 68% of those diagnosed with the disorder (SAMHSA, 2013; based on *DSM-IV-TR* criteria). The most common forms of treatment are medications (e.g., antidepressants), psychotherapy/counseling or a combination of the two. In 2012, 45% of all individuals who had a major depressive episode used a combination of psychotherapy/counseling and medications, while 14.1% used psychotherapy/counseling only, and 6.6% used medication only (SAMHSA, 2013). More than half of the individuals who received medication for their major depressive episode did so from their general practitioner (SAMHSA, 2013). For those who sought psychotherapy/counseling, many accessed outpatient counseling at a mental health clinic or private practice in the community. About .8% reported they were hospitalized at some point in the year (SAMHSA, 2013). Others may have received treatment that included more intensive interventions such as case management to help with access to services and subsistence or day treatment to provide all-day support and supervision when needed. Because such a small percentage of clients seek psychotherapy/counseling alone (SAMHSA, 2013), it is likely that counselors who work with clients who have major depressive disorder do so as part of a treatment team. Counseling is an essential part of treatment, as there is ample empirical evidence for its effectiveness, particularly cognitive-behavioral and interpersonal techniques (e.g., Paradise & Kirby, 2005).

Bipolar I Disorder

Bipolar I disorder affects roughly .6% of the population (APA, 2013). It is a lifelong disorder, as nearly all of the individuals who have one manic episode will have multiple episodes in their lifetime (APA, 2013). Symptoms of bipolar I disorder can be detrimental to relationships, daily functioning and financial stability of the individual who is diagnosed with the disorder. The cyclical nature of bipolar I disorder leads to instability, as the episodes of depression, mania and remission each have a different impact on the individual's life. During episodes of depression, the impact is similar to that caused by major depressive disorder, as described above. In contrast, some individuals with bipolar I disorder report enjoying manic episodes as they escalate because of improved mood, energy and productivity. However, elevated mood often comes with dangerous grandiosity, distractibility and impulsivity. During periods of remission when symptoms are mild or absent, the person may attempt to repair the consequences of their manic episodes (e.g., excessive shopping) and depressive episodes (e.g., neglected chores).

Few people seek treatment on their own during manic episodes. Initiating or expanding treatment during a manic episode is important to prevent irreparable damage and to ensure safety. Grandiosity combined with risky behaviors can lead to physical injuries and property damage, and the euphoria of elevated mood can quickly

shift to anger and irritability. For more than half of individuals with bipolar I disorder, depressive episodes follow manic episodes (APA, 2013), which is especially dangerous to the individual if he or she is not in a secure treatment setting.

Treatment. Roughly two-thirds of those diagnosed with bipolar I disorder receive treatment each year (Merikangas et al., 2007). The most common form of treatment is medication, including mood stabilizers, atypical antipsychotics and antidepressants (NIMH, n.d.-b). While many of these medications are effective in managing symptoms, some can have serious side effects resulting in additional medical risks such as liver or kidney issues. These risks, in addition to lack of insight into illness, preference for manic episodes, and comorbid personality or addictive disorders can lead to noncompliance (Colom et al., 2000).

In treating bipolar I disorder, individual therapy and family counseling may be helpful in developing client interpersonal skills and increasing quality of life (NIMH, n.d.-b; Steinkuller & Rheineck, 2009). There is clear empirical evidence suggesting that individuals who participated in psychotherapy more frequently and for a longer duration in addition to using medication had a better prognosis than those who participated in fewer sessions over a shorter period of time (NIMH, n.d.-b.; Steinkuller & Rheineck, 2009). These individuals appeared to recover more quickly, have fewer relapses and require fewer hospitalizations.

Schizophrenia

About 1% of Americans have schizophrenia (NIMH, n.d.-c). Only one in five people diagnosed with the disorder return to the level of functioning they had before onset. Therefore, schizophrenia is often a pervasive and lifelong disorder that can severely impair daily functioning. Individuals with schizophrenia may have difficulty completing tasks, focusing on assignments and processing information. Because onset of schizophrenia is typically in early adulthood, a person's ability to make educational progress and develop necessary skills to obtain a job or receive a degree may be limited (NIMH, n.d.-c). The lack of income threatens stable housing and basic needs. Therefore, individuals diagnosed with schizophrenia are likely to require financial assistance from family or public funding sources.

Treatment. The most common form of treatment for schizophrenia is medication. Antipsychotic medications focus on managing symptoms by reducing the severity and frequency of hallucinations and delusions. However, not all medications work for all individuals, and many can have significant side effects such as blurred vision, tremors, drowsiness, sensitivity to sunlight and tardive dyskinesia (NIMH, n.d.-c). Because of these side effects and the cognitive impairments inherent in the disorder, medication compliance is a problem, as individuals will sometimes skip doses or discontinue medications altogether.

Other forms of treatment are recommended in conjunction with medication, such as counseling and psychoeducation to teach individuals skills for daily functioning, interacting with others, self-care and employment (NIMH, n.d.-c). Person-centered approaches may be effective, as a lack of insight into the illness may cause clients to become skeptical about treatment (Kreyenbuhl, Nossel, & Dixon, 2009; NIMH, n.d.-c).

In summary, roughly one in 10 Americans will experience major depressive disorder, bipolar I disorder or schizophrenia each year, and two-thirds of those will seek treatment for their conditions (Merikangas et al., 2007; SAMSHA, 2013). Counselors who provide essential services to clients may have first made the diagnosis long ago and likely are part of a treatment team. With the release of the new version of the *DSM*, best practice is to review and revise diagnoses for all clients to ensure accuracy. Each change to major depressive disorder, bipolar I disorder and schizophrenia is described below.

Changes from *DSM-IV-TR* to *DSM-5*

Major Depressive Disorder

The mood disorders section in the *DSM-IV-TR* began with criteria for mood episodes (e.g., depressive, manic, hypomanic; APA, 2000). The mood episodes were later included in the diagnostic criteria for mood disorders. The *DSM-5* has a different format. The mood disorders are separated into two sections: depressive disorders, and bipolar and related disorders. In addition, the *DSM-5* lists complete criteria for each disorder in one place, rather than separating the mood episodes from the rest of the criteria for each disorder (e.g., major depressive disorder).

Major depressive disorder now includes a streamlined list of symptoms and examples of each so that clinicians may better understand the intended criteria. Part A of the diagnostic criteria did not change: "Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure" (APA, 2013, p. 160). The nine symptoms that follow are very similar to the symptoms listed in the *DSM-IV-TR*. The first symptom focuses on depressed mood and is the hallmark of the disorder. The example "hopeless" was added to increase clarity about the way clients may describe how they feel. The requirement of clinically significant distress did not change, nor did the verbiage about symptoms being caused by a medical condition or better explained by other disorders.

A significant change was made to criterion E of *DSM-IV-TR*, often called the bereavement exclusion. The previous rule was that major depressive disorder could not be diagnosed following the death of a loved one or other loss unless the symptoms persisted for 2 months (as opposed to the typical 2-week required duration). The *DSM-5* states that responses to loss may include feelings and behaviors that match those listed in the criteria for major depressive disorder. Although the reaction may be considered understandable given the recent loss, if criteria for the disorder are met, the diagnosis may be given regardless of the circumstances. Representatives from the depressive disorders work group explained their rationale for this change at the 2013 American Psychiatric Conference (Zisook, 2013). They noted that the criteria for diagnosis should be defined without regard to the cause of the symptoms. Many things can cause or exacerbate depressive symptoms. Most individuals who suffer losses (e.g., death of a loved one, divorce, unemployment) will not experience symptoms severe enough to merit diagnosis (Zisook, 2013). Severe depressive symptoms, such as those required for diagnosis of major depressive disorder, merit clinical attention regardless of external causes in the individual's life. The *DSM-5* gives the counselor the discretion to diagnose major depressive disorder in grieving clients if the symptoms have been met for 2 weeks, rather than requiring 2 months of suffering as noted in the *DSM-IV-TR*.

Perhaps more relevant to those clients who have long been diagnosed with major depressive disorder, the *DSM-5* included changes to the specifiers. *Single episode*, *recurrent*, *mild*, *moderate* and *severe* are again included with different numerical codes for each. One change is that *psychotic features* can now be added to mild, moderate or severe levels. Specifiers about *seasonal pattern*, *catatonia*, *melancholia*, and *atypical features* remain with expanded descriptors in some cases. *Postpartum* was changed to *peripartum* because symptoms often emerge during pregnancy, which would not fit the *DSM-IV-TR* specifier of postpartum, but is important nonetheless. The term *peripartum* means during the pregnancy or in the 4 weeks following delivery, so this specifier can be used in both cases. In addition, new specifiers were added: *with anxious distress* and *with mixed features*. Both are described below.

The specifier *with anxious distress* is to be used when the client experiences two or more of the following symptoms most days: feels tense, feels unusually restless, worry disrupts concentration, fears something bad

will happen, or worries about losing control of oneself. The severity of the anxious distress specifier also is noted, using mild, moderate, moderate-severe and severe. This specifier was added because clinicians frequently described the presence of some symptoms of anxiety in their clients who have major depressive disorder. Often, the threshold is not met for a comorbid anxiety disorder diagnosis but the symptoms are significant nonetheless. Clients with anxious distress are more likely to attempt suicide and may require more intensive treatment than those with depression alone; therefore, it is essential that counselors note these symptoms in the diagnosis (APA, 2013; Goldberg, 2013).

The specifier *with mixed features* applies when clients have subthreshold hypomania most days in addition to symptoms of depression. For example, the criteria require three of the following symptoms to be present nearly every day during most of the days in the depressive episode: elevated mood, grandiosity, pressured speech, racing thoughts, increased energy, involvement in risky activities or decreased need for sleep. This specifier is important to note because clients who have major depressive disorder with mixed features are more likely to develop bipolar I or bipolar II disorder (Coryell, 2013). Because treatment for the bipolar disorders is often different from treatment for major depressive disorder, noting the mixed features is important to help clinicians track changes in the client's symptoms closely.

A final change in *DSM-5* that affects multiple diagnoses, including major depressive disorder, is the inclusion of cross-cutting symptom measures (APA, 2013). The goals of these instruments are to help clinicians understand client symptoms more effectively, to identify co-morbidity of symptoms and to track changes in symptoms over time (Clarke, 2013). The Level 1 Cross-Cutting Symptom Measure–Adult is a self-report measure for adults to provide clinicians with information about the presence of symptoms. This measure also can be completed by an informant if the individual lacks the capacity to do so (APA, 2013). The measure consists of 23 questions related to 13 domains such as depression, anger and anxiety. To complete the measure, an individual rates the presence of symptoms over the past 2 weeks using a 5-point Likert scale (0 = *none or not at all* to 4 = *severe or nearly every day*). For most of the domains, a rating of mild or greater on any item is an indicator for a clinician to conduct a more detailed assessment (APA, 2013). However, for suicidality, psychosis and substance use, endorsement of any symptoms necessitates further investigation. Further assessment may include the use of the level 2 cross-cutting symptom measures. These domain-specific instruments are not included in *DSM-5,* but are available online at http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures (APA, 2014). The cross-cutting measures can be administered numerous times for initial and ongoing assessment. Clinical trials revealed that the measures are easy to use and incorporate into daily practice and provide meaningful information (Clarke, 2013). Clients who participated in the clinical trials felt better understood by their clinicians when they used these measures (Clarke, 2013). Therefore, cross-cutting measures in the *DSM-5* can be excellent information-gathering tools that counselors can use to make informed diagnostic and treatment decisions.

Bipolar I Disorder

As described above, bipolar I disorder is now included in a separate section for bipolar and related disorders, and the complete diagnostic criteria list is found in one place (i.e., APA, 2013, p. 123). The core prerequisite for bipolar I disorder continues to be the presence of at least one manic episode, and several of the criteria for the manic episode were revised to increase clarity.

For example, criterion A for a manic episode in the *DSM-IV-TR* describes "a distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)" (APA, 2000, p. 362). In the *DSM-5*, the phrase "and present most of the day, nearly every day" was added to clarify how frequently the mood state must be present (APA, 2013, p. 124). Similarly, in criterion B, the *DSM-5* specifies that the elevated, expansive or irritable mood must "represent a noticeable change from

usual behavior" (APA, 2013). In the list of seven symptoms under criterion B, two were revised for greater clarity. The *DSM-5* notes that distractibility can be either reported or observed. Psychomotor agitation is defined as "purposeless non-goal-directed activity" (APA, 2013, p. 124).

Criterion C from the *DSM-IV-TR* states that the episode in question must truly be a manic episode, not a mixed one. Mixed episodes were removed entirely from the *DSM-5* as they were exceedingly rare, and instead a specifier denoting mixed features was added (Coryell, 2013). Additionally, the exclusion for manic-like episodes caused by antidepressant treatment was also removed. That is, in the *DSM-IV-TR*, if the manic symptoms follow antidepressant treatment such as medication, light therapy or electroconvulsive treatment, they are not considered symptoms of a true manic episode. In the *DSM-5*, that exclusion is removed. If a client displays symptoms that meet the criteria for a manic episode, the diagnosis can be given regardless of previous antidepressant treatment.

Additional descriptors also were added to the criteria for a hypomanic episode, although the diagnosis continues to describe individuals who display manic symptoms, but do not show clinically significant impairment. The elevated, expansive or irritable mood must be present for 4 consecutive days and for most of the day. The antidepressant exclusion also is removed from the hypomanic episode criteria, but clinicians are cautioned not to interpret irritability or agitation as sufficient for diagnosis. Bipolar I specifiers for severity and course remain the same, except that the psychotic features specifier is now coded separately from severity, as described above in major depressive disorder. Similarly, the specifiers *with anxious distress* and *with mixed features* were added to the bipolar disorders.

Schizophrenia

How schizophrenia is conceptualized did not change from the *DSM-IV-TR* to the *DSM-5,* but the criteria for the diagnosis did change significantly. In the *DSM-IV-TR*, criterion A stated that two or more of the following symptoms must be present for at least 1 month unless successfully treated: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms. An additional note permitted diagnosis with only one symptom of delusions or hallucinations if bizarre or persistent. The *DSM-5* increases the diagnostic threshold by requiring the presence of delusions, hallucinations or disorganized speech (as opposed to the diagnosis being possible based on disorganized behavior and negative symptoms alone) and removing the single symptom option for meeting criterion A. The duration requirement remains the same as in *DSM-IV-TR*: at least 1 month of active symptoms in a time period of at least 6 months of impairment. Criterion D remains the schizoaffective disorder and mood disorder exclusion, but the text was revised to define how frequently manic or depressive symptoms must be present in order to meet full criteria. The *DSM-5* specifies that mood symptoms must be present for at least half of the total duration of active and residual psychotic phases in order to be considered (APA, 2013).

The specifiers about the episodic or continuous symptoms and remission were changed in the *DSM-5* and the subtypes were removed entirely. Course specifiers were revised for clarity and now include descriptors for first episode, multiple episodes, continuous or unspecified. These specifiers are not used until the disorder has been present for 1 year. In the *DSM-5*, the subtypes are not included as part of the diagnosis. For example, *DSM-IV-TR* language such as *295.30 schizophrenia, paranoid type* is no longer used. The types are still described under the delusional disorder criteria, but the differentiated types of schizophrenia are no longer endorsed. Almost all schizophrenia diagnoses are now coded 295.90 schizophrenia, except for those individuals who have catatonia, and their diagnoses are coded 293.89. In the *DSM-5*, the Clinician-Rated Severity of Psychosis Symptoms Severity scale was added (APA, 2013). The rating scale and other instruments are available online at http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures. Clinicians are instructed to rate the presence of symptoms over the previous 7 days across eight dimensions. The dimensions, rated from 0 (*no presence*)

to 4 (*severe and present*), are hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms, impaired cognition, depression and mania. During a presentation on the *DSM-5* (Malaspina, 2013), representatives from the schizophrenia spectrum and other psychotic disorders work group explained that symptoms for individuals with schizophrenia can change over time. Therefore, the scale was designed to help clinicians note their detailed observations of the client and track changes in symptoms across time.

Case Examples

Some of the changes previously described are minor and do not result in revisions to the core diagnoses of clients with these disorders. However, some changes might impact diagnoses, and others might alter the way we describe the disorder or the name of the disorder itself. As with the conversion from the *DSM-III-R* (APA, 1987) to the *DSM-IV* (APA, 1994), the process will be ongoing. The cases below illustrate possible changes that counselors, supervisors and counselor educators can make immediately in their practices.

Martha: Major Depressive Disorder

Martha is a 47-year-old married mother of two. She works part-time as a real estate agent and is active in her Episcopal church. Her husband spends long hours at work and is often required to travel out of town. Her two adult children live nearby. Her father is deceased and her mother's health is unstable, although she lives at a local assisted living facility.

Martha's depression was first recognized by her family doctor when she was 23. He was not familiar with the *DSM* (*DSM-III-R* at that time), but recognized symptoms of sadness, hopelessness, emptiness and fatigue. He began prescribing her a relatively new drug called Prozac. Martha experienced improvement immediately. For the next 6 years Martha's family doctor managed her depression with occasional dosage increases and biannual checkups. Just before her 30th birthday, Martha experienced her first severe depressive episode and attempted suicide. She had delivered her second child three weeks prior, and her husband found her after she cut her wrists.

Martha was hospitalized and received her first full mental health evaluation. Using the *DSM-IV* criteria, she was diagnosed with *296.33 major depressive disorder, recurrent, severe without psychotic features, with postpartum onset*. Recurrent was given because of her self-reported symptom and treatment history. Her present symptoms far exceeded the minimum required for diagnosis, so the episode was considered severe. Martha was coherent, denied hearing voices or seeing images, and showed no evidence of delusions, so no psychotic features were noted. The suicide attempt occurred 3 weeks after delivery and depressive symptoms had been present for at least a week at that point; therefore, Martha met criteria for the postpartum onset specifier. Martha also experienced anxiety about caring for her children and managing her life but did not meet criteria for an anxiety disorder. Following discharge from the hospital, Martha continued to see the psychiatrist she met while hospitalized and began seeing a licensed professional counselor. Martha worked well in counseling and experienced long periods of remission and several more moderate depressive episodes in the 17 years that followed. She maintained regular appointments with her psychiatrist for medication management and sought counseling at times of increased depression or stress.

Presently, Martha has just resumed seeing a licensed professional counselor. She describes sadness, low energy, hopelessness, limited pleasure, insomnia, and stressors related to aging, her family relationships and her mother's failing health. Her psychiatrist adjusted her medication and suggested that she resume counseling for additional support. Although the counselor has worked with Martha previously, the resumption of services is a great opportunity to revisit her diagnosis.

At this time, Martha's core diagnosis of *major depressive disorder, recurrent* remains appropriate. Upon further exploration of Martha's symptoms, the counselor finds that seven symptoms are present; therefore, Martha's depressive episode is considered moderate. The new specifier *with moderate anxious distress* is also appropriate for inclusion because of Martha's reported stressors. Martha feels tense and restless nearly every day. She worries about her children, her health, and her mother, and has difficulty focusing on her work and household tasks. She describes the feelings of depression as present all day, every day, and the stress, worry, and tension as present nearly every day, particularly when she attempts to "face reality" and engage with others or accomplish tasks around the house. A review of Martha's history shows that anxious distress may have always been present during her depressive episodes. It was noted during her hospitalization and during previous counseling services, but had not reached the severity level necessary for an anxiety disorder diagnosis. Noting these important symptoms using the specifier may help Martha get the treatment she needs. Using the cross-cutting symptom measures to track her symptoms of depression and anxiety may be helpful as the counselor works to find the most effective ways to facilitate progress on Martha's goals.

During Martha's 24 years of treatment, she has had several slightly different diagnoses. Her first unspecific depression diagnosis from the family physician was further identified by the evaluation she had while an inpatient using the *DSM-IV* criteria for *296.33 major depressive disorder, recurrent, severe without psychotic features, with post-partum onset*. Martha's current diagnosis of *296.32 major depressive disorder, recurrent, moderate, with moderate anxious distress* is reflective of both her history and current presentation.

Bo: Bipolar I Disorder

Bo is a 32-year-old single male. He lives alone with the support of his mother and brother. He has held numerous entry-level jobs for short time periods. Presently, he is unemployed and receiving Social Security Disability benefits. He receives treatment through a local mental health center. His current treatment program is called Program of Assertive Community Treatment (PACT; National Alliance on Mental Illness, 2014) and includes psychiatry, counseling, case management and vocational rehabilitation services. Some services occur at the local mental health center and some occur in his home or in the community.

Bo was first diagnosed (per the *DSM-IV-TR*) with *296.90 mood disorder, not otherwise specified* when he was 24. During adolescence, Bo had a history of drug and alcohol use, academic and behavioral problems at school, and minor legal infractions. At age 22, Bo had a stable job, one year of sobriety, and lived alone for the first time. After 3 days of no returned phone calls, Bo's brother began a search and finally found him in an apparent manic state. He was rambling enthusiastically about a new business in media promotions. He had drawings and notes scattered across his apartment with what appeared to be logos for the business. Bo told his brother that he would make millions of dollars with his connections in the music industry. Bo's brother was concerned given that Bo had no such relationships. With just a little prodding, Bo revealed he had already spent his life savings and sold his motorcycle to get the business started and needed to borrow more money to "make it happen." He became furious and destructive when his brother challenged his ideas. Bo's brother was alarmed and took him to the local emergency room for an evaluation.

The emergency clinician met with Bo and determined that although some of his symptoms matched those for a manic episode, his vague symptom history and relatively short duration of illness precluded diagnosis of bipolar I disorder at that time. Bo was diagnosed with *296.90 mood disorder, not otherwise specified* and referred to a crisis stabilization program for treatment and further evaluation. Bo was resistant to treatment because he did not believe his behavior to be inappropriate. After 4 days in crisis stabilization, Bo's mood changed dramatically and he entered a major depressive episode. He expressed suicidal intent and was hospitalized. His diagnosis was revised to *296.53 bipolar I disorder, most recent episode depressed, severe without psychotic features* (per *DSM-IV-TR* at the time).

Over the next 10 years Bo received ongoing psychiatric and mental health services from the community mental health center. His engagement in treatment waxed and waned, as did his symptoms. He had several six- to eight-month periods of remission and was hospitalized five additional times for severe manic or depressive episodes. Presently, Bo has been unemployed for 5 years and receiving Social Security Disability benefits for 3 years. After his most recent hospitalization, Bo was referred to the PACT team. His mother and brother continue to be supportive and are delighted to have the more intensive program to help Bo achieve stability again. In the PACT program, client services are reviewed every 120 days. Bo's review is due, which is an opportunity to check his diagnosis for compliance with the new *DSM-5* criteria.

Bo has stabilized somewhat since discharge from the hospital but continues to have attenuated manic symptoms. At the time of hospitalization, Bo's symptoms were present most of the day, every day, so he exceeded the clarified requirement for diagnosis in the *DSM-5*. Among other symptoms, Bo demonstrated distractibility, but his grandiosity precluded him from acknowledging that. However, clinicians observed the distractibility in session; therefore, the criterion was met. Bo did not demonstrate mixed features or experience psychosis so those revisions in the *DSM-5* are not pertinent here. He has received antidepressant treatment in the past but not in recent months; therefore, no extra consideration is necessary to ensure that criterion F is met. Given this presentation, Bo's diagnosis remained *bipolar I disorder, most recent episode manic*.

Because of the improvement Bo has achieved since hospital discharge, *in partial remission* can be added to the diagnosis at his 120-day review. Therefore, his complete diagnosis is *296.45 bipolar I disorder, most recent episode manic*, *in partial remission*. Bo's improvement is tenuous, however, and requires ongoing medication compliance and supportive counseling. The PACT team is designed to provide this long-term support and counselors are an essential part of that program (Salyers & Tsemberis, 2007). Given the complexity and variability of Bo's symptoms, a counselor may find it helpful to administer regularly the Level 1 Cross-Cutting Symptom Measure to track changes over time. The counselor also could use the more specific Level 2 assessment to track symptoms in a particular domain such as mania.

Saul: Schizophrenia

Saul is a 20-year-old unemployed male. He currently lives in the home he grew up in with his mother, father and 14-year-old brother. Since graduating from high school, Saul has worked a part-time job while taking classes at a local community college.

Saul was first hospitalized at age 18 after he began to tell his family that he was a messenger from God. Saul's family had a difficult time understanding what Saul was telling them, as it was uncharacteristic of him, but initially they were not concerned. However, Saul's parents became more alarmed as they noticed he was increasingly more preoccupied with the belief. They also observed that his grades began to suffer and he was spending more time reading religious material online rather than socializing with his friends. After a couple of months of this and no signs of improvement, Saul's parents contacted the local community mental health center for help.

Saul was voluntarily hospitalized because of uncharacteristic behavior. While in the hospital, he received a mental health evaluation from a psychiatrist. The psychiatrist noted that there was no evidence of disorganized speech, catatonia or negative symptoms. Additionally, Saul denied auditory and visual hallucinations and the psychiatrist did not observe Saul responding to internal stimuli. Saul reported that his mood was good and the psychiatrist noted no evidence of mania or depression. However, Saul routinely told the psychiatrist he was a messenger from God and often perseverated on the topic. He also reported the detrimental impact that his work as God's messenger was having on his life. Saul and his family both denied any history of substance use,

and a toxicology screen was negative for common street drugs, which could have led to the sudden change in behavior. In sum, there was no medical explanation for the change in behavior.

Using the *DSM-IV-TR*, the psychiatrist diagnosed Saul with *295.30 schizophrenia, paranoid type*. He cited evidence of a bizarre delusion, thus requiring only one symptom to meet criterion A. The psychiatrist noted paranoid type, which was appropriate given Saul's preoccupation with the religious themes and the grandiose nature of the delusions. The psychiatrist prescribed an antipsychotic medication for Saul and encouraged him to follow up with a counselor and psychiatrist in the community for outpatient care.

After discharge from the hospital, Saul received outpatient treatment from a licensed professional counselor and a psychiatrist. Saul took his medication each day with the assistance of his parents, who monitored his compliance. Saul was able to complete high school and started courses at a community college and worked part-time. However, when Saul was 20 years old, his psychiatrist noted a concern in his blood work, which was likely a side effect of the medication he was taking. Saul's psychiatrist changed his medication because of this concern.

Quickly, Saul's preoccupation with his role as a messenger from God returned. Saul again began to have difficulty with course work and dropped out of school. He was fired from his job because his boss became frustrated that Saul was frequently late, took too long to complete tasks at work and appeared disengaged. There also were reports that he was scaring customers by asking about their religious faith and commitment to God. When Saul stopped showering, his parents requested that he be evaluated again and he was hospitalized for a second time.

During his second hospitalization, Saul received another mental health evaluation from a psychiatrist. Saul continued to insist that he was a messenger from God and he perseverated on religious themes. Saul said he felt compelled to act on God's commands, which he now heard as a deep male voice. The psychiatrist noted that Saul's responses in session were delayed, he frequently asked for questions to be repeated and he seemed to be responding to his hallucinations. Using the *DSM-5*, the psychiatrist diagnosed Saul with *295.90 schizophrenia, multiple episodes, currently in acute episode*. There was evidence of at least two symptoms for criterion A: evidence of delusions, auditory hallucinations and diminished emotional expression. Saul reported feeling sad or down at times, but through Saul's report and the treatment team's observations, it appeared that this occurred less than half the time during an active psychotic phase, which ruled out schizoaffective disorder.

Saul's psychiatrist also completed a quantitative severity assessment using the Clinician-Rated Dimensions of Psychosis Symptom Severity from the *DSM-5* (APA, 2013). Saul's psychiatrist rated the impairment in the past seven days for the eight areas of functioning using a scale ranging from 0 (*no presence*) to 4 (*present and severe*). The psychiatrist rated hallucinations as 4 because Saul was frequently responding to voices, which limited his ability to track their conversation and impaired his functioning. Delusions were rated 3 because of pressure to follow God's commands. This pressure caused Saul to isolate from others, research religious themes, neglect his personal hygiene and pester customers about their beliefs, which cost him his job. Disorganized speech was rated 0 as the psychiatrist noted Saul's speech was normal. The psychiatrist did not observe any abnormal psychomotor behavior; therefore, it was scored 0 as well. Negative symptoms were rated 3 as Saul displayed moderate decrease in facial expressiveness. Impaired cognition was rated 3 as Saul was unable to take classes and concentrate at work. Thus his functioning was significantly below what would be expected from an individual of Saul's age and socioeconomic status. Depression was rated as 1 because Saul reported feeling sad or down some of the time, but did not appear preoccupied with sadness. Mania was rated as 0 because there was no evidence of elevated or expansive mood.

The Clinician-Rated Dimensions of Psychosis Symptom Severity scale may be repeated at hospital discharge or during subsequent treatment in order to track Saul's progress. Additionally, Saul's counselor may find it useful to track his symptoms using the Level 1 Cross-Cutting Symptom Measure. While in the hospital, Saul endorsed sadness on some of the past seven days. If Saul were to respond to an item on the depression domain as mild or greater, the counselor could also use the Level 2 Cross-Cutting Symptom Measure for depression to gather additional information.

Saul's case is unique in that his initial presentation 2 years ago would not have met full criteria for schizophrenia had it occurred after the *DSM-5* was released. At the time of his second hospitalization, when the *DSM-5* was in use, the additional symptoms made it clear that schizophrenia was the appropriate diagnosis for Saul. Ongoing treatment may help Saul achieve stability and improve his quality of life, and the repeated use of the severity scale may help track his progress.

Conclusion

These scenarios illustrate which changes from *DSM-IV-TR* to *DSM-5* had an impact on preexisting client diagnoses. Note the core diagnoses did not change, only some of the terminology and specifiers. Why then is it important for counselors to learn about the changes and review existing client diagnoses? Consider the following reasons for careful diagnostic practice.

Section E.5 of the *ACA Code of Ethics* (ACA, 2014) mandates that counselors maintain careful, culturally sensitive diagnostic practices. Section A.2.b further requires counselors to take steps to explain the diagnosis and its implications to their clients. Some clients, particularly those who were previously diagnosed, may not have had the opportunity to discuss the meaning of their diagnosis or its implications with a mental health professional. They may have little knowledge at all or longstanding misconceptions. Some clients, like Martha, may have been first diagnosed by a primary care physician who was not familiar with the *DSM* and the specific features of depression that it details. The release of the *DSM-5* is an opportunity to check in and use counseling and advocacy skills to help clients develop an accurate and healthy understanding of their diagnoses. The cross-cutting symptom measures provide a stimulus to engage in a dialogue about the client's symptoms and treatment needs. Use of these instruments gathers valuable information and helps clients feel better understood (Clarke, 2013). Counselors can have a tremendous influence on how clients conceptualize their mental health, so taking advantage of this opportunity to shape it in a positive way is a great service to the client.

Additionally, converting to *DSM-5* criteria and terminology is essential to meet the common language goal that inspired the initial creation of the *DSM*. Each edition of the *DSM* has included revisions that changed the criteria or titles used to describe disorders, but instant conversion to the new terms does not happen in practice. For example, manic-depressive disorder became bipolar I disorder in the third revision of the *DSM* almost 35 years ago (APA, 1980) and yet some people still use the antiquated term today. Attending to the changes and discussing them with colleagues and clients will speed adoption of the new common language. Modeling ethical, careful, current diagnostic practices may have a positive ripple effect on colleagues as well. If counselors, supervisors and counselor educators all use the terms and criteria set forth by *DSM-5*, we can more easily communicate within our profession and across treatment teams.

In fact, the *DSM-5* authors made a special call for all clinicians to use the *DSM-5* language as carefully and specifically as possible. For example, authors asked clinicians to avoid using the catchall diagnoses at the end of each section (i.e., *not otherwise specified* in the *DSM-IV-TR*, *other specified* and *unspecified* in the *DSM-5*; Phillips, 2013). These diagnoses are sometimes necessary in the short term (as in the case of Bo above),

but with additional information a more defined diagnosis is often possible. The *DSM-5* authors also called on clinicians to attend carefully to the use of specifiers (e.g., Coryell, 2013; Goldberg, 2013). Many of the revisions to specifiers were made because of the potential impact on client treatment. For example, the presence of anxious distress (as in Martha above) complicates the treatment of depression. Noting the anxious distress in the diagnosis itself brings attention to those symptoms and reduces the likelihood that they will be overlooked. For Martha, it seems that when she is able to rise up out of her depression enough to engage in life, her anxiety surges and discourages her from attempting engagement again. It may be that her anxiety needs to be addressed before she can effectively work on her depression.

The *DSM-5* authors also cautioned clinicians that one of the limitations of the *DSM-IV-TR* was that too many diagnostic criteria overlapped, leading to what is called "artificial co-morbidity" (Tandon, 2013). Individuals may be diagnosed with multiple disorders because of shared criteria. For example, a client's irritability, social withdrawal and anger outbursts may have underlying depression, mania, delusional thinking or anxiety. These are features of bipolar disorder, major depressive disorder, schizoaffective disorder and post-traumatic stress disorder, and the convolution can lead to overdiagnosis and, ultimately, improper treatment. Arriving at more accurate diagnoses quickly will lead to better care for clients, and *DSM-5* includes a new tool to help counselors do just that. The Cross-Cutting Symptoms Measures allow a counselor to assess for the presence of symptoms that are related to multiple diagnoses and consider whether a specifier or comorbid diagnosis is appropriate (APA, 2013).

Accurate diagnoses also are essential to ongoing research on these and other mental health conditions. Medical record research is increasingly common, particularly with the adoption of electronic medical records and the conglomeration of large managed care companies. That means that the diagnoses counselors record on billing documentation or enter into client medical records are likely to become part of a behind-the-scenes research project. Often these projects use data points such as diagnosis, number of hospitalizations, frequency of outpatient sessions and medication dosages to conduct large-scale analyses of trends or outcomes in treatment. Research like this does not require client or clinician consent because the existing data is anonymized and permission is granted *en masse* by the organization. Important evidence-based practice recommendations come from this type of study; therefore, using the most accurate documentation, whether the counselor intends to participate in research or not, is important for valid studies.

In sum, the *DSM-5* has set forth changes in criteria and terminology used to describe major depressive disorder, bipolar I disorder and schizophrenia. Counselors can take advantage of this opportunity to help clients develop a healthy, accurate understanding of their diagnoses. The release of the *DSM-5* also is an opportunity to revise diagnoses, paying careful attention to specifiers, in order to adhere to the common language it establishes. Thorough, accurate diagnoses support the selection of effective treatments and ongoing research on the treatment of these conditions. All counselors, supervisors and counselor educators can work together as we address these important goals.

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