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Volume 4, Issue 3

Special Issue: Counseling and the *DSM-5*

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The Professional Counselor

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Special Issue: *Counseling and the DSM-5*

Dr. Matthew R. Buckley, Guest Editor

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The intended audiences for *TPC* include National Certified Counselors, counselor educators, mental health practitioners, graduate students, researchers, supervisors, and the general public.

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Back to Basics: Using the *DSM-5* to Benefit Clients

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Matthew R. Buckley

It is a pleasure to introduce this special *DSM-5* edition of *The Professional Counselor*, which provides a solid primer regarding changes in the *DSM-5* diagnosis process and how these changes will likely impact mental health professionals. Changes within the *DSM-5* have prompted counselors to revisit the basics of diagnosis and consider the cessation of certain conventions (e.g., the multiaxial system) and what these changes mean to counselors as they perform their vital work for the benefit of clients. The unprecedented inclusion of various mental health professionals in the development of the *DSM-5* is an inherent recognition of how this tool is being used across a wide range of professional disciplines that focus on psychopathology. I hope these articles not only inform, but encourage further research into the practical use of the *DSM-5*, "stimulate new clinical perspectives" in mental illness (American Psychiatric Association [APA], 2013, p. 10), and inspire continued professional dialogue around *DSM* nosology and the diagnostic processes.

Keywords: *DSM-5*, **diagnosis, psychopathology, mental illness, multiaxial system**

The fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-5*) is an update of a major diagnostic tool (APA, 2013). The manual was originally designed to help mental health professionals within a wide variety of disciplines assess and conceptualize cases in which people were suffering from mental distress. This conceptualization is important in that it facilitates an understanding in a common language toward the development of treatment planning to address complex and entrenched symptomology. The *DSM* has undergone numerous iterations and represents the current knowledge of mental health professionals about mental illness (APA, 2013). One of the primary aims of the *DSM-5* workgroups was to align the manual with the current version of the *International Classification of Diseases* (*ICD-9*). In addition, political, social, legal and cultural dynamics influenced the development of the *DSM-5*—and not without controversy (Greenberg, 2013; Locke, 2011; Linde, 2010; Pomeroy & Anderson, 2013). As with any tool, concerns have emerged about the potential of misuse. It is the professional responsibility of skilled and ethical mental health counselors and other professionals to prevent misapplication of the manual (American Counseling Association [ACA], 2014, E.1.b, E.5.a–d). Walsh (2007) succinctly noted that "the primary goal of the *DSM* is to enhance the care of individuals with psychiatric disorders" (p. S3).

The introduction of the *DSM-IV-TR* states that the *DSM* has been used by numerous mental health practitioners (APA, 2000), with no mention of their investment as legitimate stakeholders in the process of *DSM* development. Well before the final revision of the *DSM-5*, various mental health professionals, organizations and other relevant collaborators helped formulate the manual in unprecedented capacities. In the introduction to the *DSM-5* (APA, 2013) the authors intentionally state that numerous stakeholders were involved in *DSM-5* development including counselors and "patients, families, lawyers, consumer organizations, and advocacy groups" (p. 6). Of particular note was the inclusion of national organizations such as the ACA in the form of a

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DSM-5 task force, which submitted position statements and recommendations to the APA. Various mental health professionals participated directly in the formulation of the *DSM-5*, primarily in field trials which "supplied valuable information about how proposed revisions performed in everyday clinical settings" (p. 8). Much of the data supports the use of more than 60 cross-cutting and severity symptom measures (see http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures).

Clinical Utility

First (2010) reported that utilizing broad and diverse populations of mental health professionals provides rigor for clinical utility. Achieving clinical utility within the *DSM* diagnostic processes meets the following four objectives:

1. to help clinicians *communicate* clinical information to other practitioners, to patients and their families, and to health care systems administrators;
2. to help clinicians *implement effective interventions* in order to improve clinical outcomes;
3. to help clinicians *predict the future* in terms of clinical management needs and likely outcomes; and
4. to help clinicians *differentiate disorder from non-disorder* for the purpose of determining who might benefit from disorder-based treatments. (First, 2010, p. 466)

Any changes to the *DSM* were framed within the context of how they might be utilized by all mental health professionals, including revisions to definitions of diagnoses and symptoms, proposed diagnostic categories, dimensional assessment (including *cross-cutting*), and a renewed emphasis on severity specifiers. Ultimately, the consideration was whether the revised manual would be accepted and utilized by the practitioners it proposed to serve (APA, 2013; First, 2010). First (2010) noted that no mandate exists requiring the use of the *DSM* by any professional, and that other tools used to arrive at an *ICD* diagnosis exist or are in development (e.g., the NIMH Research Domain Criteria initiative; APA, 2013; Nussbaum, 2013). The *DSM-5* workgroups were challenged to revise the manual in order to make it user-friendly and maintain its relevance among mental health professionals. Even though the manual is an imperfect resource, the goal was to enhance clinical utility.

Determining a Differential Diagnosis

In his primer on diagnostic assessment focused on the *DSM-5*, Nussbaum (2013) offers six considerations in determining a differential diagnosis that serve as an important basis for practice. These considerations or steps include the following:

- to what extent signs and symptoms may be intentionally produced;
- to what extent signs and symptoms are related to substances;
- to what extent signs and symptoms are related to another medical condition;
- to what extent signs and symptoms are related to a developmental conflict or stage;
- to what extent signs and symptoms are related to a mental disorder; and
- whether no mental disorder is present.

Each of these process steps serves as important reminders for getting back to the basics of rendering diagnoses that help inform treatment. When working with clients, these steps function as points of reference to rule out potential factors influencing misdiagnosis. Additionally, client cultural factors are essential at capturing comprehensive context for assessment and diagnosis.

Consider to what extent signs and symptoms may be intentionally produced. Signs and symptoms may be purposely feigned on the part of a client for secondary gain (e.g., financial benefits, drug seeking, disability status, attention from others, reinforcement of an identity of pathology, avoiding incarceration). Counselors

must recognize the context in which signs and symptoms occur and pay attention when something does not "fit" with how a client presents for treatment. Assessing prior mental health treatment (including outcomes), cultural factors and potential motives to fake an illness can assist counselors in making an accurate differential diagnosis.

Consider to what extent signs and symptoms are related to substances. A wise and influential professor and mentor during my graduate training said, "Always assess for substance use!" Clients can present with a variety of conditions that are induced by prescription or over-the-counter drugs, illicit substance, or herbal supplements (Nussbaum, 2013). An important emphasis within the *DSM-5* is substance-use and substance-induced disorders, which are included in many relevant diagnostic criteria (APA, 2013). Counselors are well-advised to make this determination in the initial assessment and continue to assess throughout the course of treatment.

Consider to what extent signs and symptoms are related to another medical condition. Clients present with signs and symptoms that may be caused by or coincident with another medical condition in a variety of ways. Nussbaum (2013) defined possible manifestations including (a) medical conditions that directly or indirectly alter signs and symptoms, (b) treatments for medical conditions that alter signs or symptoms, (c) mental disorders and/or treatments that may cause or exacerbate medical conditions, or (d) both a mental disorder and a medical condition that are not causally related. Counselors should gather medical information from the client and appropriately follow up with medical personnel as needed to ensure proper and accurate diagnosis, which will lead to more targeted and effective treatment.

Consider to what extent signs and symptoms are related to a developmental conflict or stage. A primary strength of counseling professional identity is the focus on human development as a key factor in client distress and resiliency. The counseling practice of "meeting clients where they are" includes where they are developmentally. Counselors must recognize where incongruence exists between what clients present and the expected behaviors or characteristics of their particular developmental stage. Nussbaum (2013) stresses the importance of gathering a comprehensive psychosocial history to determine expected developmental milestones. Being on the lookout for developmental delays, regressive behaviors of an earlier developmental period, primal defense mechanisms, or signs of "a developmental conflict in a particular relationship" (p. 201) will help ensure that all essential contextual factors are addressed when making a diagnosis.

Consider to what extent signs and symptoms are related to a mental disorder. The definition of mental disorder has not changed significantly from previous versions of the *DSM*: a mental disorder is "a syndrome characterized by clinically significant disturbance in…cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes…[and] usually associated with significant distress or disability in social, occupational, or other important activities" (APA, 2013, p. 20). Identifying mental disorders, or the process of diagnosis, involves more than clear-cut observations and often includes the consideration of complex factors involving comorbidity, symptom clusters "that may be part of a more complex and unified syndrome that has been artificially split in the diagnostic system" (Nussbaum, 2013, p. 202), overlap between diagnostic criteria, genetic predisposition, and the mutual influence of two or more conditions. Counselors must be careful to consider the presence of these factors, consult when necessary, and take into account differential diagnosis to determine the most appropriate diagnosis given the verbal and observable data available.

Consider whether no mental disorder is present. Sometimes a client may present with symptoms that do not meet the full diagnostic criteria for a mental disorder, despite significant distress in social, occupational or other areas of functioning. In these cases, utilizing the *not otherwise specified* or *unspecified* diagnoses may be

warranted in order to provide opportunities for deeper inquiry. For example, the symptoms of a disorder may be a secondary reaction to an identifiable social stressor that may justify a diagnosis of an adjustment disorder. The possibility exists that there may not be a diagnosis present (Nussbaum, 2013), and in these cases, counselors and other mental health professionals are challenged to make that decision in the face of pressures to diagnose.

Cultural Implications

It is imperative that counselors take their clients' social and cultural influences into account when assessing and diagnosing. Culture impacts all aspects of diagnosis and treatment, including how and when treatment is sought; power differentials between clients and mental health professionals; the age, gender, ethnicity, race, religion, sexual orientation, and socioeconomic status of both clients and mental health professionals; how illness is defined by both; and how problems are conceptualized and addressed within the context of culture (Lewis-Fernández et al., 2014; Tomlinson-Clarke & Georges, 2014).

Two decades of experience using the Outline for Cultural Formulation (OCR), which was introduced in the *DSM-IV* (APA, 1994), evolved into the Cultural Formulation Interview (CFI) now contained in the *DSM-5*, comprised of 16 semi-structured questions designed to collect data in a more consistent and efficient manner. Like other dimensional, cross-cutting and severity measures developed specifically for the *DSM-5*, the CFI was field tested at 12 sites representing several countries to determine feasibility and usefulness (Lewis-Fernández et al., 2014). For the first time, culture in its varied manifestations has been intentionally incorporated into the *DSM* nosology through a specific assessment instrument. "The CFI follows a person-centered approach to cultural assessment…designed to avoid stereotyping, in that each individual's cultural knowledge affects how he or she interprets illness experience and guides how he or she seeks help" (APA, 2013, p. 751). Counselors are encouraged to utilize the CFI as a way to understand their clients more meaningfully and to aid in clinical utility.

The *TPC* Special Issue: Counseling and the *DSM-5*

Because the *DSM-5* is a tool for mental health professionals to utilize in their conceptualization of client distress, understanding how to use the *DSM* effectively is at the heart of this special issue published by *The Professional Counselor* (*TPC*). Readers will find a variety of articles that will assist mental health professionals by providing important context for most of the salient changes within the *DSM-5* (APA, 2013) from the perspective of professional counseling. Inherent in each of these contributions is the theme of getting back to the basics in not only understanding the *DSM-5* conceptually, but also providing ideas for putting concepts into practice.

An essential element in understanding and using the *DSM-5* effectively is exploring the foundational and historical roots of this complex nosology. Dailey, Gill, Karl, and Barrio Minton (2014); Gintner (2014); and Kress, Barrio Minton, Adamson, Paylo and Pope (2014) offer excellent overviews of salient changes within the *DSM-5* that impact clinical practice, including how the *DSM* has evolved over time. While there is necessary redundancy on key points (e.g., elimination of the multiaxial format, implementation of cross-cutting symptom measures, closer alignment with the *ICD* coding system), each article provides an important and unique perspective. Dailey et al. (2014) offer important perceptions on changes within the *DSM-5* including how changes evolved historically and the philosophical foundations behind those changes, especially those that clash with the philosophical underpinnings of counseling. The authors review the implications of such changes for professional counselors. Gintner (2014) provides an excellent context regarding the harmonization of the *DSM-5* with the *ICD*, the inclusion of cross-cutting symptom measures and dimensional assessment, and how the manual is organized. The article focuses on how counselors might respond to these changes. Kress et al. (2014)

offer an important perspective on the removal of the multiaxial convention used by mental health professionals for over three decades and the implications for counselors in the practice of assessment and diagnosis. These authors provide an important context for the decision to terminate the multiaxial system including advantages and disadvantages of *DSM-5* changes.

King (2014) describes the practical application of diagnostic criteria and the use of cross-cutting dimensional assessments. This perspective offers a backdrop on which to compare current practice and how it may alter with use of the *DSM-5*. This article focuses on clinical utility and ensuring that the *DSM-5* remains a guide to assessment, diagnosis and treatment. Schmit and Balkin (2014) give a comprehensive review of the cross-cutting, dimensional and severity measures from the perspective of psychometric instrumentation, including the practical application of validity and reliability. These authors underscore *DSM-5* assessments as *soft measures* and provide important cautions to counselors using these instruments in their work with clients, including the importance of developing multiple data points.

Understanding specific diagnostic categories is essential to good clinical practice. Welfare and Cook (2014); Kenny, Ward-Lichterman and Abdelmonem (2014); and Jones and Cureton (2014) provide solid descriptions of specific diagnostic criteria and emphasize areas essential to our understanding of developmental and demographic strata. Welfare and Cook (2014) tackle chronic and persistent mental illness manifested in diagnoses within the following categories: schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, and depressive disorders. Clinical examples help contextualize the process of assessing and diagnosing these disorders and provide a detailed example of effectively utilizing each step of the diagnostic process. Kenny et al. (2014) provide a cogent overview of the changes made to the "Feeding and Eating Disorders" chapter, including the addition of binge eating and avoidant/restrictive food intake disorders, severity criteria for anorexia nervosa based on body mass indexes, and how the diagnosis of eating disorder not otherwise specified (EDNOS) has changed as a result. Jones and Cureton (2014) offer important perspectives on significant changes to the "Trauma- and Stressor-Related Disorders" chapter and how these changes may impact clinical practice. The authors discuss how diagnostic criteria have been developed for both children and adults and how cross-cutting symptoms (e.g., panic and dissociation) manifest in a range of disorders. Another significant change to this category is the acknowledgement of sexual abuse as a traumatic event; this takes post-traumatic stress disorder (PTSD) out of the often associated realm of combat veterans and into more common and insidious manifestations of trauma.

Counselors should consider the aforementioned changes to the *DSM-5* in the context of their counselor identity. Maintaining professional identity and promoting a wellness- and strength-based perspective continues to be an important concern for the counseling profession and the training of counselors. Tomlinson-Clarke and Georges (2014) provide an overview of maintaining professional identity in the process of assessment and diagnosis within a system representing the medical model. A particular strength is the inclusion of how multicultural competency is crucial in using the *DSM-5* effectively, which is an essential basic foundation to sound practice. Implications for counselor preparation also are a focus. Finally, Frances (2014) provides a critical commentary of how the *DSM* has been used by pharmaceutical companies to leverage significant profits at the cost to consumers of mental health services and our economy. As the former chair of the *DSM-IV* task force, Frances reminds counselors and other mental health professionals of their essential place within treatment and cautions counselors to use the *DSM* in a balanced manner. His comments are consistent with advocacy inherent in our profession for treatments that promote client resilience, and address psychosocial and environmental factors that impact client functioning.

Conclusions

This special *TPC* issue on counseling and the *DSM-5* provides a compilation of articles covering the history of the *DSM*, structural and categorical changes, the process of diagnosis, implications for practice, and cautions and criticisms. These articles validate the unique and important perspective counselors bring to their work, and challenge all mental health professionals to use the *DSM-5* accurately. The *DSM* continues to evolve, and its advocates have made significant strides in reaching out to a variety of professionals; one manifestation of this outreach is the development of the *DSM-5* website (see http://www.psychiatry.org/practice/dsm/dsm5). Counselors have the opportunity to use the *DSM-5*, provide feedback directly to the APA, and help shape and influence future editions of this diagnostic tool. This is an important way counselors can advocate for their clients as well as their profession, and shape how the *DSM* is used to help treat those suffering from mental and emotional distress.

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References

American Counseling Association. (2014). *2014 code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Arlington, VA: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Dailey, S. F., Gill, C. S., Karl, S. L., & Barrio Minton, C. A. (2014). Historical underpinnings, structural alterations and philosophical changes: Counseling practice implications of the *DSM-5*. *The Professional Counselor*, *4*, 166–178. doi:10.15241/sfd.4.3.166

First, M. B. (2010). Clinical utility in the revision of the *diagnostic and statistical manual of mental disorders* (*DSM*). *Professional Psychology: Research and Practice*, *41*, 465–473.

Frances, A. (2014). *DSM*, psychotherapy, counseling and the medicalization of mental illness: A commentary from Allen Frances. *The Professional Counselor*, *4*, 282–284. doi:10.15241/afm.4.3.282

Gintner, G. G. (2014). *DSM-5* conceptual changes: Innovations, limitations and clinical implications. *The Professional Counselor*, *4*, 179–190. doi:10.15241/ggg.4.3.179

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry.* New York, NY: Blue Rider Press.

Jones, L. K., & Cureton, J. L. (2014). Trauma redefined in the *DSM-5*: Rationale and implications for counseling practice. *The Professional Counselor*, *4*, 257–271. doi:10.15241/lkj.4.3.257

Kenny, M. C., Ward-Lichterman, M., & Abdelmonem, M. H. (2014). The expansion and clarification of feeding and eating disorders in the *DSM-5*. *The Professional Counselor*, *4*, 246–256. doi:10.15241/mck.4.3.246

King, J. H. (2014). Clinical application of the *DSM-5* in private counseling practice. *The Professional Counselor*, *4*, 202–215. doi:10.15241/jhk.4.3.202

Kress, V. E., Barrio Minton, C. A., Adamson, N. A., Paylo, M. J., & Pope, V. (2014). The removal of the multiaxial system

in the *DSM-5*: Implications and practice suggestions for counselors. *The Professional Counselor*, *4*, 191–201. doi:10.15241/vek.4.3.191

Lewis-Fernández, R., Krishan Aggarwal, N., Bäärnhielm, S., Rohlof, H., Kirmayer, L. J., Weiss, M. G. . . Lu, F. (2014). Culture and psychiatric evaluation: Operationalizing cultural formulation for *DSM-5*. *Psychiatry*, *77*, 130–154. doi:10.1521/psyc.2014.77.2.130

Linde, L. E. (2010). *American Counseling Association DSM response to APA.* Retrieved from http://www.counseling.org/counselors/ACA-DSM-response.pdf

Locke, D. (2011). *American Counseling Association DSM-5 Letter to APA.* Retrieved from http://www.counseling.org/resources/pdfs/aca_dsm-5_letter_11-11.pdf

Nussbaum, A. M. (2013). *The pocket guide to the DSM-5 diagnostic exam.* Arlington, VA: Author.

Pomeroy, E. C., & Anderson, K. (2013). The *DSM-5* has arrived. *Social Work*, *58*, 197–200. doi:10.1093/sw/swt028

Schmit, E. L., & Balkin, R. S. (2014). Evaluating emerging measures in the *DSM-5* for counseling practice. *The Professional Counselor*, *4*, 216–231. doi:10.15241/els.4.3.216

Tomlinson-Clarke, S. M., & Georges, C. M. (2014). *DSM-5*: A commentary on integrating multicultural and strength-based considerations into counseling training and practice. *The Professional Counselor*, *4*, 272–281. doi:10.15241/stc.4.3.272

Walsh, B. T. (2007). DSM-V from the perspective of the *DSM-IV* experience. *International Journal of Eating Disorders*, *40*, S3–S7. doi:10.1002/eat.20397

Welfare, L. E., & Cook, R. M. (2014). Revising diagnoses for clients with chronic mental health issues: Implications of the *DSM-5*. *The Professional Counselor*, *4*, 232–245. doi:10.15241/lew.4.3.232

Historical Underpinnings, Structural Alterations and Philosophical Changes: Counseling Practice Implications of the *DSM-5*

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Regardless of theoretical orientation or work setting, professional counselors should have a thorough understanding of the American Psychiatric Association's (APA) fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). This article includes an overview of the most recent revision process and identification of key structural and philosophical changes in the *DSM-5*. The authors conclude with a summary of practice implications for counselors, including specific guidance for recording diagnoses, using diagnostic specifiers and incorporating emerging assessment measures.

***Keywords: DSM-5*, diagnosis, diagnosis specifiers, assessment, American Psychiatric Association**

By definition, counseling is a professional relationship between client and counselor based on empowerment, rooted in diversity, and committed to accomplishing mental health, wellness, education and career goals of individuals, families and groups (Kaplan, Tarvydas, & Gladding, in press). To accomplish these goals, counselors often include diagnosis as an essential component of the counseling process. Even counselors who work in settings where they are not traditionally responsible for diagnostic assessment must possess a comprehensive understanding of diagnostic nosology and nomenclature. Such an understanding helps providers recognize diagnostic concerns and participate in interdisciplinary discussions and treatment decisions regarding consumers who experience distress or disability. Despite competitors such as the *ICD-10 Classification of Mental and Behavioural Disorders* (World Health Organization [WHO], 1992), the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; APA, 2013) is the world's standard reference for evaluation and diagnosis of mental disorders (Eriksen & Kress, 2006; Hinkle, 1999; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008).

The purpose of this article is to present major structural and philosophical changes within the *DSM-5* (APA, 2013) in order to make those changes more accessible to counselors. We, the authors, describe how these changes translate to current counseling practice and how they will help counselors utilize the revised nomenclature system. To better understand these changes, we believe it is important to first review development of the *DSM* and the most recent revision process.

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History of the *DSM*

The original *DSM* was psychiatry's first attempt to standardize mental illness classification. Published in 1952 by the APA, the *DSM* represented an alternative to the WHO's sixth edition of the *ICD* that included a section on mental disorders for the first time (APA, 2000). Focused on clinical utility, the first *DSM* was grounded in psychodynamic formulations of mental disorders (Sanders, 2011). Emphasizing Adolf Meyer's psychobiological view, this version of the manual claimed that mental illness represented "reactions" of the personality to psychological, social or biological aspects of client functioning (APA, 2000). A particularly noteworthy characteristic of the *DSM*'s first edition is that of the 106 conditions it included, only one diagnosis—adjustment reaction of childhood/adolescence—was relevant to youth (Sanders, 2011).

The APA published the next iteration, the *DSM-II,* in 1968. This version included 11 diagnostic categories and 182 disorders (APA, 1968). Reflecting significant changes in theoretical ideology, the focus of the manual shifted from psychopathology (i.e., reactions) to psychoanalysis (i.e., neuroses and psychophysiological disorders; Sanders, 2011). Authors of the *DSM-II* maintained a narrative focus when describing disorders.

APA began working on the *DSM-III* in 1974 and published it in 1980. This iteration differed significantly from previous editions and represented a dramatic shift to a more medically focused model (APA, 1980; Wilson, 1993). Authors of the *DSM-III* stressed use of empirical evidence to develop diagnoses and claimed theoretical neutrality, signaling a clear attempt to separate the *DSM* from its psychoanalytic origins (Maser, Kaelber, & Weise, 1991). A new multiaxial system included attention to biopsychosocial conceptualization. For the first time, the *DSM-III* contained descriptive diagnoses with a focus on positivistic, operationally defined and explicit diagnostic criteria (Wilson, 1993); narrative text also included information such as familial patterns, cultural considerations and gender (Sanders, 2011). The age of empirically based treatments had arrived, and widespread use of the *DSM-III* became commonplace.

Intended at first only to include minor changes, the APA published substantial modifications to text and diagnostic criteria within the *DSM-III-R* (1987); as a result, a number of scholars criticized the document intensely (APA, 2000; Blashfield, 1998; Scotti & Morris, 2000). Expanding to 297 diagnoses, Axis I descriptions nearly exceeded 300 pages, while attention to Axes IV and V remained limited to just a few pages. Many scholars continued to question the multiaxial system and validity of field trials (Rogler, 1997).

Heavy critique of the *DSM-III* and the *DSM-III-R* led to relatively mild changes to the *DSM-IV*, published in 1994 (APA, 2000). At nearly seven times the length of the original *DSM*, this version totaled 365 diagnoses in 886 pages. A text revision (*DSM-IV-TR*) published in 2000 included wording modifications to ensure nonstigmatizing, person-first language (Scotti & Morris, 2000). The APA also included empirically based information for each diagnosis and diagnostic code modifications to maintain consistency with the *ICD-9* (APA, 2000). Like its predecessors, the *DSM-IV-TR* was heavily critiqued by scholars due to a heavy emphasis on a medical model and rigid classification systems (Eriksen & Kress, 2006; Ivey & Ivey, 1998; Scotti & Morris, 2000). Issues of comorbidity, questionable reliability, controversial diagnoses and excessive use of *not otherwise specified* (NOS) diagnoses were hot topics among critics (Beutler & Malik, 2002). APA identified these issues as driving forces for structural and philosophical changes in the *DSM-5* (APA, 2013).

The *DSM-5* Revision Process

Beginning in 1999, one year before the APA published the *DSM-IV-TR*, the APA began working on a new edition, which would be more scientifically based, increase clinical utility and maintain continuity with previous

editions (APA, 2014a). APA released an initial research agenda focused on nomenclature, neuroscience, developmental science, personality disorders, and the relationship between culture and psychiatric diagnoses (APA, 2000; Kupfer, First, & Regier, 2002). The APA, the National Institute of Mental Health (NIMH), and the WHO held 13 conferences between 2004 and 2008 in which stakeholders discussed relevant diagnostic questions and solicited feedback regarding potential changes in nosology. Resulting themes facilitated the research base and fueled the agenda of the *DSM-5* working groups (see Kupfer et al., 2002 for the full *DSM-5* research agenda).

In 2007, the APA officially commissioned the *DSM-5* Task Force, made up of 29 members including David J. Kupfer, M.D., Chair; and Darrel A. Regier, M.D., M.P.H., Vice-Chair (APA, 2014a). Kupfer and Regier provided clear direction to eradicate the use of NOS diagnoses, eliminate functional impairment as necessary components of diagnostic criteria, and use empirically based evidence to justify diagnostic revisions (Gever, 2012; Reiger, Narrow, Kuhl, & Kupfer, 2009). With these marching orders, each working group proposed draft criteria and justification for changes.

Between April 2010 and June 2012, the *DSM-5* Task Force facilitated three rounds of public comment and two field trials (Clarke et al., 2013; Jones, 2012a; Narrow et al., 2013; Regier et al., 2013). The APA Board of Trustees reviewed final revisions in December 2012 and published the *DSM-5* in May 2013. Although no professional counselors were invited to serve on the *DSM-5* Task Force, several professional counseling associations served as important advocates during the revision process (Dailey, Gill, Karl, & Barrio Minton, 2014).

Major Structural Changes

The general format of the *DSM-5* (APA, 2013) is quite different from that of the *DSM-IV-TR* (APA, 2000). Although roughly the same number of disorders is included in both editions, structural similarities end here. The *DSM-5* (APA, 2013) includes three major sections, revised chapter organization, cross-cutting symptom and severity measures, adoption of a nonaxial system and enhanced coverage of cultural considerations (Dailey et al., 2014). As with previous versions, the text includes a number of appendices related to terminology and coding.

Section I: *DSM-5* Basics

Section I of the new manual includes an introduction to the *DSM-5* (APA, 2013) and general instructions on how to use the updated manual, including attention to nonaxial diagnosis and coding considerations. Counselors who diagnose in accordance with the *DSM-IV-TR* (2000) may be surprised to see that the APA eliminated both the multiaxial classification system and the Global Assessment of Functioning (GAF) scale. Never required for diagnosis, the APA removed the multiaxial system on the premise that it may lead to inaccurate, oversimplified conceptualization regarding complexities of physical, biological and emotional concerns. Furthermore, removal of the GAF was due to claims of insufficient clinical utility and reliability.

Less radical structural changes discussed in Section I include harmonization of language with the forthcoming *ICD-11*. The *DSM-5* (APA, 2013) incorporates two sets of *ICD* codes: *ICD-9* codes (for immediate use, presented in black print) alongside *ICD-10* codes (for use upon nationwide conversion to *ICD-10-CM* coding expected October 1, 2015, presented in parentheses and in gray print). In addition, authors address consideration for implementing new *other specified* and *unspecified* disorder criteria, which present more specific alternatives to previous NOS diagnoses.

Section II: Diagnostic Criteria and Codes

Section II includes 20 diagnostic classifications or chapters, four more than the *DSM-IV-TR* (2000), and a significantly revised organization with attention to development and etiology in hopes of enhancing clinical utility (Brown & Barlow, 2005; Kupfer et al., 2002). For example, classifications more frequently diagnosed in childhood and believed to have similar root causes, such as neurodevelopmental disorders (most of which were formerly known as disorders usually diagnosed in infancy, childhood or adolescence), appear first. Diagnostic classifications more commonly seen in older adults and believed to have similar root causes, such as neurocognitive disorders (most of which were formerly known as delirium, dementia, and amnestic and other cognitive disorders), appear much later in the text.

The *DSM-5* Task Force reorganized disorders into new chapters based on research regarding etiology as well as similarity in symptom experience or manifestation. For example, anxiety disorders, which were previously grouped together, now appear in three distinct chapters: "Anxiety Disorders," "Obsessive-Compulsive and Related Disorders," and "Trauma- and Stressor-Related Disorders." Extrication of trauma- and stressor-related disorders allows diagnoses that result from traumatic external events or triggers to be grouped together in a more meaningful way (APA, 2013). Because they are diagnostically unique yet often triggered by traumatic events, the chapter "Dissociative Disorders" immediately follows the chapter "Trauma- and Stressor-Related Disorders."

The *DSM-5* Task Force also attended to etiology and development when choosing the order of diagnoses within chapters. This represents a shift from presenting more highly specified disorders first in previous editions of the manual. For example, the chapter "Feeding and Eating Disorders" opens with diagnostic criteria for pica, rumination disorder and avoidant/restrictive food intake disorder (previously classified as disorders usually first diagnosed in infancy, childhood and adolescence) before covering disorders more classically associated with adolescence and adulthood (e.g., anorexia nervosa, bulimia nervosa, binge-eating disorder).

Section III: Emerging Measures and Models

Counselors should not overlook the third and final section of the *DSM-5* (Dailey et al., 2014). Section III includes a variety of measures and models in development, including assessment measures, cultural formulation tools, a proposed personality disorders model and conditions for further study (e.g., Internet gaming disorder, nonsuicidal self-injury). Section III does not represent formal changes in nosology or diagnostic processes; rather, most elements are included to enhance clinical use by clinicians and fuel investigations by researchers.

Proposed assessment measures comprise a major component of Section III. Level 1 cross-cutting symptom measures are tools designed to screen for a broad range of presenting concerns in adults (13 domains) and children (12 domains). In turn, Level 2 cross-cutting symptom measures facilitate more focused assessment of Level 1 domains flagged as concerning. The print version of the *DSM-5* also includes a sample dimensional assessment related to psychosis and a reprinting of the WHODAS 2.0, a tool to assess disability and impairment. Most proposed assessment measures are not included in the print version of the *DSM*-5. For example, the *DSM-5* website currently includes many Level 2 cross-cutting symptom measures and disorder-specific severity measures intended to be used as dimensional assessments for some of the most frequently diagnosed concerns. Counselors can find more information about these tools and additional dimensional assessment tools not included in the print version of the *DSM-5* by viewing Online Assessment Measures (APA, 2014b) and reading resources provided by Jones (2012b) and Narrow et al. (2013).

Finally, authors of the *DSM-5* (APA, 2013) devoted special attention to diverse ways in which individuals experience and describe distress. This fosters accurate communication so that counselors may better

differentiate pathology from nonpathology when working with diverse clients (Dailey et al., 2014). As we will discuss below, counselors may use the cultural formulation interview to talk with clients about symptoms, cultural understanding of concerns and implications for treatment. The *DSM-5* Appendix also includes a glossary of cultural concepts of distress.

Major Philosophical Changes

Two major philosophical changes will modify the ways in which counselors approach diagnosis, assessment and communication with other professionals when using the *DSM-5* (Dailey et al., 2014). The first is movement away from a purely descriptive diagnostic model (i.e., a traditional medical perspective) toward a neurobiological model. This approach is grounded in client functioning as opposed to strict pathology, and includes research in genetics, neuroimaging, cognitive science and pathophysiology (Kupfer et al., 2002). The second philosophical change is a shift away from a strictly categorical classification system toward a more dimensional approach to nosology (Dailey et al., 2014).

A Neurobiological Perspective

The first major philosophical change involves a shift in focus from phenomenological interpretations toward identifiable pathophysiological origins (Dailey et al., 2014; Kupfer et al., 2002). Simply stated, the traditional medical model focuses on treating the problem, and the newer functional model focuses on treating and better understanding the problem. Diagnostic assessment has shifted from *what* to *what and why*. Previous iterations of the *DSM* based disorders purely on symptom identification and behavioral observations. As mentioned previously, APA reordered this iteration of the manual to align more clearly with a pathophysiological model that includes attention to etiology, neuroscientific evidence and functional changes associated with or resulting from disease or injury. This shift is consistent with national priorities for deeper understanding of mental illness (Kupfer & Reiger, 2011).

The *DSM*-5 Task Force incorporated text regarding neurobiology throughout the document, including standing descriptions of genetic and physiological risk factors, prognostic indicators and biological markers that may impact one's experience with disorder. As noted previously, the lack of clear differentiation between mental and physical disorders served as a major reason for removal of the multiaxial system. The *DSM-5* also includes several semantic changes that are philosophical, and possibly strategic, in nature. Whereas the *DSM-IV-TR* included reference to general medical conditions, the *DSM-5* references disorders due to *another* medical condition. This implies that mental health concerns are, in essence, medical concerns. These seemingly innocuous philosophical shifts send a powerful message regarding the nature of a disorder and, in turn, assumptions about treatment.

As noted in the section regarding structural changes, some diagnostic classifications that were combined previously due to analogous symptomology now stand alone because of research regarding disorder etiology. Aside from the previously mentioned division of anxiety disorders into three separate classifications, mood disorders have been divided into two distinct chapters: "Bipolar and Related Disorders" and "Depressive Disorders." This philosophical and in some cases structural modification is intended to reflect an emphasis on improved clinical utility and to "encourage further study of underlying pathophysiological processes that give rise to diagnostic comorbidity and symptom heterogeneity" (APA, 2013, p. 13). An example of "underlying pathophysiological processes" is the previous placement of attention-deficit/hyperactivity disorder (ADHD) as a disruptive behavior disorder within the first chapter of the *DSM-IV-TR*. Given abundant genetic links to ADHD (Rowland, Lesesne, & Abramowitz, 2002), it did not make sense for ADHD to continue as a disruptive disorder alongside oppositional defiant disorder and conduct disorder. ADHD is now classified within the neurodevelopmental disorders chapter of the *DSM-5*.

In accordance with a neurobiological perspective, the *DSM-5 Task Force* eliminated the chapter "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence" and replaced it with a neurodevelopmental disorders chapter. Disorders not considered neurodevelopmental in nature are no longer included in this chapter. For example, reactive attachment disorder, which originates from gross pathological care during infancy, is now located within the chapter "Trauma- and Stressor-Related Disorders." There also were other reasons for removing the chapter on disorders usually first diagnosed in infancy, childhood, or adolescence, such as the erroneous insinuation that these disorders manifest only in early development (Dailey et al., 2014).

Despite these changes, the impact of this shift was not as significant as neurobiologists would have hoped (Dailey et al., 2014). The *DSM-5* Task Force did not fully accept or incorporate the biological perspective, and critics claimed that clinicans might dismiss important sociocultural variations, especially given the elimination of the multiaxial assessment (Mannarino, Loughran, & Hamilton, 2007).

Dimensional Versus Categorical Nomenclature

The second major philosophical change involves attention to dimensional assessment and documentation as opposed to strictly categorical diagnosis. Categorical assessment is based on the assumption that diagnostic criteria represent independent, discrete phenomena (First, 2010; Jones, 2012b). In reality, client symptoms occur on a continuum rather than as part of a dichotomy (Dailey et al., 2014).

As noted previously, dimensional assessment scales are designed to assess frequency, duration, severity or other characteristics of a specific diagnosis (Jones, 2012b). Near the beginning of the revision process, the *DSM-5* Task Force proposed dimensional assessment measures for nearly every disorder in the manual. Following widespread concern regarding questionable psychometric data, the APA included only one dimensional assessment tool, clinician-rated dimensions of psychosis symptom severity, in the print version of the *DSM-5* (APA, 2013). The APA, however, has provided supplemental assessment tools online (APA, 2014b).

Like the neurobiological perspective, the shift toward dimensional conceptualization was neither universal nor complete. The *DSM-5* (APA, 2013) included new severity specifiers for most disorders, and it shifted forward dimensional conceptualization for several key diagnostic classifications. For example, in the *DSM-5*, *DSM-IV-TR* substance abuse and substance dependence disorders were collapsed into one new substance use disorder with severity indicators ranging from mild to severe based on the number of criteria presented by the client. Counselors are to diagnose clients who meet two or three criteria as having a *mild* disorder, those who meet four or five criteria as *moderate*, and those who have six or more criteria as *severe*. Counselors will find similar conceptualizations throughout the *DSM-5*, including in the newly conceptualized persistent depressive disorder, which combines dsythymia and chronic instances of major depressive disorder and includes 18 possible specifiers.

A more radical reflection of the dimensional approach in the *DSM-5* is the presentation of spectrum disorders rather than distinct disorders. One umbrella diagnosis—autism spectrum disorder—replaced *DSM-IV-TR* (APA, 2000) disorders of autism, Asperger's disorder, childhood disintegrative disorder, and pervasive developmental disorder. Autism spectrum disorder includes severity specifiers based on whether a client meets operationalized criteria for "requiring very substantial support, requiring substantial support, or requiring support" in social communication and restricted, repetitive behaviors domains (APA, 2013, p. 52). Similarly, the new chapter "Schizophrenia Spectrum and Other Psychotic Disorders" retains discrete diagnoses, but introduces the probability that brief psychotic disorder, schizophreniform disorder, and schizophrenia exist on a continuum. The APA (2013) claimed that the purpose of this change is to improve diagnostic efficacy, accuracy and consistency; however, critics conceptualized this as more of a philosophical shift (Dailey et al., 2014).

The APA has indicated intent to continue incorporating dimensional approaches in to future iterations of the *DSM*. For example, Section III includes a framework for diagnosing personality disorders using a hybrid categorical and dimensional model (APA, 2013). This model is based on the premise that personality dysfunction is a range of trait variations "with normal personality functioning on one end and abnormal personality functioning on the other" (Dailey et al., 2014, p. 309). Individuals who adopt the alternative model for clinical or research purposes will conceptualize clients as presenting impairment related to identity, self-direction, empathy and intimacy as they relate to five trait domains (i.e., negative affectivity, detachment, antagonism, disinhibition, psychoticism) and 25 more specific trait facets (APA, 2013). It is unclear whether the more complex dimensional model will be adopted fully in the next iteration of the *DSM* (Dailey et al., 2014).

Practice Implications for Counselors

Although many voiced concerns that the *DSM-5* would lead to drastic shifts in counselors' conceptualization of mental disorders, assessment procedures and diagnostic thresholds, this version of the "psychiatric bible" (Kutchins & Kirk, 1997, p. 1) looks remarkably similar to other iterations (Dailey et al., 2014). Despite similarities, the *DSM-5* (APA, 2013) provides groundwork for future iterations to more closely represent neurobiological and dimensional conceptualizations of mental illness. Given the professional identity of counselors, and a scope of practice that "serves to promote wellness across the lifespan . . . [including] preventing and treating mental disorders" (Kraus, 2013, p. 1), strictly neurobiological interpretations may lead consumers to ignore essential interactions between individuals and their environments. Counselors who operate from strength-based wellness approaches will likely reject the notion that all mental illness has biological foundations (Dailey et al., 2014), especially as it is a short leap from assuming biological foundations to assuming that one must treat all disorders biologically. Counselors recognize that a biological orientation could lead to erroneous diagnosis, unwarranted medications and the selection of inappropriate treatment approaches. Although one cannot deny that life experiences have powerful impacts on neurobiological systems (e.g., Badenoch, 2008; Cozolino, 2010), there is concern that too heavy a focus on neurobiology may detract from the humanistic roots of counseling (Montes, 2013).

Certainly, counselors will continue to explore ways in which these philosophical shifts will affect the practice. In the following pages, we provide concrete recommendations for rendering diagnoses consistent with the *DSM-5*. These include recommendations for using other specified and unspecified disorders, procedures for recording diagnoses, insurance transitions and possibilities for incorporating attention to assessment tools.

Other Specified and Unspecified Disorders

A primary goal of the *DSM-5* Task Force was the removal of NOS diagnoses from the *DSM* (Gever, 2012; Regier et al., 2009). This removal was based on perceived overuse of NOS by clinicians, especially when clients did not meet clear diagnostic criteria for more specific disorders (Jones, 2012b). Critics claimed that NOS diagnoses were a result of heavy reliance on "psychodynamic, a priori hypotheses" rather than "external, empirical indicators" (Kupfer & Regier, 2011, p. 672). By turning attention to more flexible dimensional diagnoses, creators of the *DSM-5* hope to provide avenues for more flexible, yet more accurate labeling of mental disorders.

Counselors now have two options when working with individuals who do not meet full criteria for a specific diagnosis: *other specified* and *unspecified*. Use of *other specified* allows counselors to indicate, by using either specifiers assigned to that particular diagnosis or a descriptive narrative, the specific reason a client does not meet criteria for a more specific mental disorder (APA, 2013). When more specific information is not available or counselors do not feel comfortable providing additional detail, they may select an *unspecified* disorder. Each

chapter of the *DSM-5* includes at least one set of these disorders (e.g., other specified elimination disorder, unspecified elimination disorder).

Some diagnostic categories, such as bipolar and related disorders and depressive disorders, include specific examples of other specified disorders. For example, a client who meets all the criteria for a major depressive disorder except the time requirement may be diagnosed with *311 other specified depressive disorder, short-duration depressive episode*. Counselors are not limited to using only these examples, as other reasons may warrant an *other specified* diagnosis (Dailey et al., 2014).

Recording Procedures

Nonaxial recording. Technically, *DSM-IV-TR* consumers were never required to present diagnoses using a multiaxial format (APA, 2013). Those who are used to the multiaxial system will simply combine previous Axis I (mental disorders and other conditions that may be a focus of treatment), Axis II (personality disorders and mental retardation), and Axis III (general medical conditions) diagnoses into one nonaxial diagnosis. Counselors also might note psychosocial stressors, environmental concerns, and impairments or disability as a brief narrative explanation relevant to the client's mental health diagnoses if these are not (a) already indicated by the diagnosis, (b) included as a diagnostic subtype or (c) indicated by a unique specifier or severity indicator for the disorder. Counselors may list V codes or 900 codes (conditions associated with neglect or sexual, physical, and psychological abuse) as stand-alone diagnoses or alongside other diagnoses as long as these are relevant to clients' presenting concerns and course of treatment. Although the *DSM-5* does not include directions for formatting, counselors should keep explanations brief and use terminology appropriate for multidisciplinary communication (Dailey et al., 2014).

Counselors who see dual-diagnosis clients, individuals with medical conditions, and those who have psychosocial and environmental concerns may be overwhelmed by how to prioritize diagnoses. One solution is to list diagnoses in order of priority and scope of the presenting problem (APA, 2013; Dailey et al., 2014). When these are different, such as an adult referred for bereavement but found to have suicidal ideation and meet criteria for major depressive disorder, the APA (2013) advised users to include a parenthetical notation differentiating between the diagnosis and reason for visit. An example diagnosis might be *296.23 major depressive disorder, single episode, severe (principal diagnosis)* and *V62.82 uncomplicated bereavement (reason for visit)*.

Counselors also may need to prioritize presentation of diagnoses when clients have relevant medical diagnoses in addition to mental health concerns. For example, a client who experiences a manic episode, uses alcohol excessively and is not able to control a preexisting thyroid disorder because of the disturbance may receive a diagnosis of: *F31.13 bipolar disorder I, current episode manic, severe*; *F10.10 alcohol use disorder, mild*; and *E06 chronic lymphocytic thyroiditis*. We chose to list alcohol use disorder second because the client appears to be most impaired by the severe manic episode, and we suspect that a pattern of alcohol use and difficulty managing chronic medical conditions are both related to the bipolar disorder.

The second example raises an important consideration regarding counselors' scope of practice. Diagnosis of medical conditions alongside mental health disorders makes sense for psychiatrists who are qualified to diagnose and treat both conditions and for mental health professionals who work in interdisciplinary settings where medical diagnoses are a matter of record (Dailey et al., 2014). Given that counselors are not qualified to diagnose medical conditions, it may be wise to refrain from including diagnostic mention of specific medical conditions unless information is gathered via official medical record or consultation. Counselors may consider including mention of client-reported medical conditions elsewhere on the clinical record or qualify medical conditions as self-reported.

***ICD* coding.** Since publication of the *DSM-III*, *ICD-9* codes have appeared next to each diagnostic classification (APA, 1980). Originally created for statistical tracking of diseases, not reimbursement, most medical systems within the United States use these codes for billing purposes. These codes are also required for use by medical insurance organizations by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In the *DSM-5* (APA, 2013), *ICD-9* codes are in black print, appear first, and typically include three digits or begin with *V*. In contrast, *ICD-10* codes are gray in print, appear in parentheses, and generally begin with the letter *F* or, if representing psychosocial or environmental factors, with the letter *Z*. The reason for including both coding sets in the *DSM-5* is that all practitioners must align with HIPAA, which requires use of *ICD-10-CM* (clinical modification) codes no later than October 1, 2015. Complete *ICD-9* and *ICD-10* codes can be found in the Appendix of the *DSM-5*, listed alphabetically and numerically.

The implication of this modification is relatively minor for counselors. Counselors should be aware that the initial printing of the *DSM-5* contained several coding errors, and not all terminology used within the *DSM-5* matches *ICD-10* exactly. Counselors can obtain a printable desk reference with coding updates by visiting the *DSM-5* coding update section on the website (APA, n.d.).

Specifiers and subtypes. In keeping with a dimensional philosophy, the *DSM-5* (APA, 2013) contains an expanded listing of specifiers and subtypes for disorders listed throughout the manual. As noted previously, this update may include a greatly expanded number of options to denote experience within a diagnosis. For example, counselors may now add the specifier *with panic attacks* to any diagnosis within the *DSM-5*. Other important changes include an expanded listing of specifiers for bipolar and related disorders and depressive disorders, such as *with catatonia*, *with anxious distress*, and *with mixed features*. These specifiers are intended to account for experiences that are often present in both types of disorders, such as elements of anxiety, but may not be part of the general criteria for the disorders (APA, 2013).

Counselors should note all relevant specifiers for each diagnosis. For more information regarding specifiers and subtypes, professional counselors can refer to the *DSM-5* for specific coding instructions and examples (APA, 2013). Despite these changes, most situations will require counselors to use the same diagnostic codes regardless of subtypes and specifiers assigned (APA, 2013; Dailey et al., 2014). There are some exceptions, however, such as when recording substance-related disorders.

Insurance Transitions

The APA (2013) noted that the *DSM-5* was "developed to facilitate a seamless transition into immediate use by clinicians and insurers to maintain a continuity of care" (p. 1). Counselors may begin using diagnostic criteria as soon as they are ready to do so. Insurance companies, other third-party payers and mental health agencies, however, may take additional time to adjust their reporting systems from *ICD-9* to *ICD-10*. This is especially true for the transition from a multiaxial to a nonaxial format (Dailey et al., 2014).

Although many counselors used the multiaxial system for diagnostic decisions, conversations and reimbursement, elimination of this system should not impact treatment decisions or reimbursement. Many third-party billing systems and government agencies collected data regarding a specific diagnosis only (previously Axis I, II and III); therefore, with the transition they should simply be reporting the same type of information.

Some insurance panels and reimbursement systems may have previously required more information, such as a GAF score, when determining eligibility for services. Given the expansion of severity indicators and specifiers contained throughout the *DSM-5*, functional impairments or specific disabilities may be noted within the nonaxial diagnosis. If this is not the case, as mentioned previously, counselors may use narrative notations alongside diagnostic labels. To the extent that functional impairment or disabilities are not listed and would

previously have been indicated in the multiaxial system, counselors will need to work closely with associated parties to identify revised reporting requirements (Dailey et al., 2014). Counselors also can use the WHODAS 2.0, found in Section III of the *DSM-5* or at www.psychiatry.org/dsm5, to more clearly indicate an individual's level of functioning (APA, 2013).

The APA initially predicted that the insurance industry would transition to *DSM-5* by December 31, 2013. This estimate was overly optimistic, however, as most third-party billing systems and government agencies have been slow to switch over to the *DSM*-5 and likely will not do so until the nationwide mandate for the use of *ICD-10* codes goes into effect on October 1, 2015. Counselors can check with their employers and third-party payers to ensure a smooth transition to the *DSM-5* in a manner consistent with local administrative procedures. The APA also is making implementation and transition updates available via their website.

Emerging Assessment Measures

As discussed previously, the *DSM-5* includes a variety of cross-cutting assessment measures, disorder-specific severity measures and interview tools for clinicians. The APA (2013) qualified all print and online assessments, including the WHODAS 2.0 and Personality Inventories, as "emerging measures" intended for further research and exploration in clinical practice. Counselors may do well to integrate attention to screening of cross-cutting symptoms and monitoring of diagnostic severity in practice.

In most cases, the tools provided by the APA are clear, direct and ready to use; however, these online assessments vary widely in format, quality and rigor of psychometric validation (Jones, 2012b). For example, the severity measure for depression is the Patient Health Questionnaire–9 (APA, 2014b; Kroenke, Spitzer, & Williams, 2001). This well-developed instrument is in the public domain, and psychometric data are easy to access and indicate a strong degree of psychometric integrity. On the other hand, the Severity Measure for Panic Disorder–Adult (Shear et al., 2001) has limited validation and few publicly available references regarding development procedures and psychometric considerations (Keough et al., 2012). From an ethical perspective, counselors who use these measures are responsible for ensuring that they do so in a manner that is within their scope of practice and includes appropriate attention to instrument validity and administration procedures. Professional counselors must adhere to ethical standards (American Counseling Association [ACA], 2014; National Board for Certified Counselors [NBCC], 2012) and best practice guidelines (Association for Assessment in Counseling, 2003) when administering and interpreting diagnostic assessments.

A potentially useful tool to enhance clinical understanding of a client's cultural worldview, the cultural formulation interview (CFI) is the APA's attempt to address critics' claims that the *DSM* has not historically included culture as part of diagnostic assessment (Dailey et al., 2014). Whereas the *DSM-IV-TR* (2000) included some cultural characteristics within its diagnostic classifications, it was clear that consumers needed more attention to psychosocial and environmental factors (Smart & Smart, 1997). The *DSM-5* has continued this trend by updating diagnostic classification to include culture-related diagnostic issues for most disorders, supplemental information about cultural concepts and inclusion of the CFI.

The CFI is a 15–20 minute semi-structured interview consisting of 16 key questions (APA, 2013). With its coverage of numerous topics related to cultural perceptions of the presenting problem, the CFI helps counselors facilitate conversations about domains such as etiological origin, specific circumstances, interpersonal support systems, and coping and help-seeking behavior. Twelve additional modules, to be used as supplements to the CFI or independent of the CFI, are provided by the APA. These modules address topics or specific populations, such as immigrants and refugees; coping and help seeking; and spiritual, religious, or moral traditions. These modules can provide a firm foundation for culturally sensitive counselors to build competence and better

understand a client's worldview from a diagnostic perspective. Even if counselors simply find the CFI a helpful tool for facilitating conversations about culture, the inclusion of the CFI in the *DSM-5* is an important step forward in helping professionals improve their understanding of cultural competence as essential to diagnostic assessment.

Perhaps most importantly, counselors do not have to use assessment measures or interview tools associated with the *DSM-5* unless those assessment measures are integrated into standard operating procedures with insurance panels or agency policies. We encourage counselors to be selective and discerning as they incorporate emerging tools into practice. Because we expect the APA to continue to release new dimensional assessment and supplemental practice tools on a rolling basis, counselors may wish to visit the *DSM-5* website and continue to assess the degree to which the recommended tools may enhance their practice.

Conclusion

Professional counselors comprise one of the largest bodies of *DSM* consumers (Frances, 2011). Regardless of background, training or theoretical orientation, counselors are responsible for understanding diagnostic practices and using them responsibly (ACA, 2014; NBCC, 2012). Counselors who are aware of recent modifications to the *DSM* position themselves for continued advancement of care systems that support "diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan et al., in press). In this article, we attended to higher-level philosophical and structural changes within the *DSM* so that counselors may deepen their understanding regarding underlying foundations and motivations for *DSM-5* revisions, even as they adopt more concrete diagnostic practices. We hope this historical and philosophical context helps counselors better advocate for a seat at the table in future *DSM* revision processes. In the meantime, counselors may use this information to make informed decisions about whether and how they will use the *DSM-5*.

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References

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (n.d.). *DSM-5 coding update*. Retrieved from http://dsm.psychiatryonline.org/DSM5CodingSupplement

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2014a). *DSM-5 overview: The future manual.* Retrieved from http://www.dsm5.org/about/Pages/DSMVOverview.aspx

American Psychiatric Association. (2014b). *Online assessment measures*. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Association for Assessment in Counseling. (2003). *Responsibilities of users of standardized tests (RUST*; 3rd ed.). Retrieved from http://aarc-counseling.org/assets/cms/uploads/files/rust.pdf

Badenoch, B. (2008). *Being a brain-wise therapist: A practical guide to interpersonal neurobiology.* New York, NY: W. W. Norton.

Beutler, L. E., & Malik, M. L. (Eds.). (2002). *Rethinking the DSM: A psychological perspective.* Washington, DC: American Psychological Association.

Blashfield, R. K. (1998). Diagnostic models and systems. In A. S. Bellack & M. Herson (Series Eds.), & C. R. Reynolds (Vol. Ed.), *Comprehensive clinical psychology: Volume 4. Assessment* (pp. 57–80). doi:10.1016/B0080-4270(73)00225-X

Brown, T. A., & Barlow, D. H. (2005). Dimensional versus categorical classification of mental disorders in the fifth edition of the *diagnostic and statistical manual of mental disorders* and beyond: Comment on the special section. *Journal of Abnormal Psychology*, *114*, 551–556. doi:10.1037/0021-843X.114.4.551

Clarke, D. E., Narrow, W. E., Regier, D. A., Kuramoto, S. J., Kupfer, D. J., Kuhl, E. A., . . . Kraemer, H. C. (2013). DSM-5 field trials in the United States and Canada, Part I: Study design, sampling strategy, implementation, and analytic approaches. *American Journal of Psychiatry*, *170*, 43–58.

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain* (2nd ed.). New York, NY: W. W. Norton.

Dailey, S. F., Gill, C. S., Karl, S. L., & Barrio Minton, C. A. (2014). *DSM-5 learning companion for counselors*. Alexandria, VA: American Counseling Association.

Eriksen, K., & Kress, V. E. (2006). The *DSM* and the professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling*, *28*, 202–217.

First, M. B. (2010). Clinical utility in the revision of the *diagnostic and statistical manual of mental disorders* (*DSM*). *Professional Psychology: Research and Practice*, *41*, 465–473. doi:10.1037/a0021511

Frances, A. J. (2011, June 3). Who needs DSM-5? A strong warning comes from professional counselors. *Psychology Today.* Retrieved from http://www.psychologytoday.com/blog/dsm5-in-distress/201106/who-needs-dsm-5

Gever, J. (2012, May 10). *DSM-5: What's in, what's out.* Retrieved from http://www.medpagetoday.com/MeetingCoverage/APA/32619

Health Insurance Portability and Accountability Act of 1996, 42 U.S.C.A. § 1320d *et seq.* (West 1996).

Hinkle, J. S. (1999). A voice from the trenches: A reaction to Ivey and Ivey (1998). *Journal of Counseling & Development*, *77*, 474–483. doi:10.1002/j.1556-6676.1999.tb02475.x

Ivey, A. E., & Ivey, M. B. (1998). Reframing *DSM-IV*: Positive strategies from developmental counseling and therapy. *Journal of Counseling & Development*, *76*, 334–350. doi:10.1002/j.1556-6676.1998.tb02550.x

Jones, K. D. (2012a). A critique of the *DSM-5* field trials. *The Journal of Nervous and Mental Disease*, *200*, 517–519.

Jones, K. D. (2012b). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development*, *90*, 481–487. doi:10.1002/j.1556-6676.2012.00059.x

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (in press). 20/20: A Vision for the Future of Counseling: *The new consensus definition of counseling*. Retrieved from http://www.counseling.org/docs/david-kaplan's-files/consensus-definition-of-counseling.docx?sfvrsn=2

Keough, M. E., Porter, E., Kredlow, M. A., Worthington, J. J., Hoge, E. A., Pollack, M. H., . . . & Simon, N. M. (2012). Anchoring the panic disorder severity scale. *Assessment*, *19*, 257–259. doi:10.1177/1073191112436668

Kraus, K. (2013). *20/20 A vision for the future of counseling: Endorsement letter.* Alexandria, VA: American Counseling Association. Retrieved from http://www.counseling.org/docs/david-kaplan's-files/endorsement-letter.docx?sfvrsn=2

Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9 validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*, 606–613.

Kupfer, D. J., First, M. B., & Regier, D. A. (Eds.). (2002). *A research agenda for DSM-V.* Washington, DC: American Psychiatric Publishing.

Kupfer, D. J., & Regier, D. A. (2011). Neuroscience, clinical evidence, and the future of psychiatric classification in *DSM-5*. *The American Journal of Psychiatry*, *168*, 672–674.

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy: DSM: The psychiatric bible and the creation of mental disorders.*

New York, NY: Free Press.
Mannarino, M. B., Loughran, M. J., & Hamilton, D. (2007, October). *The professional counselor and the diagnostic process: Challenges and opportunities for education and training.* Program presented at the annual Association for Counselor Education and Supervision Conference, Columbus, OH.
Maser, J. D., Kaelber, C., & Weise, R. E. (1991). International use and attitudes toward *DSM-III* and *DSM-III-R*: Growing consensus in psychiatric classification. *Journal of Abnormal Psychology*, *100*, 271–279. doi:10.1037/0021-843X.100.3.271
Montes, S. (2013, November 1). Facing a rising tide of personality disorders. *Counseling Today*, *56*(5), 33–39.
Narrow, W. E., Clarke, D. E., Kuramoto, S. J., Kraemer, H. C., Kupfer, D. J., Greiner, L., & Regier, D. A. (2013). DSM-5 field trials in the United States and Canada, Part III: Development and reliability testing of a cross-cutting symptom assessment for DSM-5. *The American Journal of Psychiatry*, *170*, 71–82.
National Board for Certified Counselors. (2012). *NBCC code of Ethics.* Greensboro, NC: Author.
Regier, D. A., Narrow, W. E., Clarke, D. E., Kraemer, H. C., Kuramoto, S. J., Kuhl, E. A., & Kupfer, D. J. (2013). DSM-5 field trials in the United States and Canada, Part II: Test-retest reliability of selected categorical diagnoses. *The American Journal of Psychiatry*, *170*, 59–70.
Regier, D. A., Narrow, W. E., Kuhl, E. A., & Kupfer, D. J. (2009). The conceptual development of *DSM-V*. *The American Journal of Psychiatry*, *166*, 645–650.
Rogler, L. H. (1997). Making sense of historical changes in the *diagnostic and statistical manual of mental disorders*: Five propositions. *Journal of Health and Social Behavior*, *38*, 9–20.
Rowland, A. S., Lesesne, C. A., & Abramowitz, A. J. (2002). The epidemiology of attention-deficit/hyperactivity disorder (ADHD): A public health view. *Mental Retardation and Developmental Disabilities Research Reviews*, *8*, 162–170. doi: 10.1002/mrdd.10036
Sanders, J. L. (2011). A distinct language and a historic pendulum: The evolution of the *diagnostic and statistical manual of mental disorders*. *Archives of Psychiatric Nursing*, *25*, 394–403. doi:10.1016/j.apnu.2010.10.002
Scotti, J. R., & Morris, T. L. (2000). Diagnosis and classification. In M. Hersen & R. T. Ammerman (Eds.), *Advanced abnormal child psychology* (2nd ed., pp. 15–32). Mahwah, NJ: Lawrence Erlbaum.
Shear, M. K., Rucci, P., Williams, J., Frank, E., Grochocinski, V., Vander Bilt, J., . . . & Wang, T. (2001). Reliability and validity of the Panic Disorder Severity Scale: Replication and extension. *Journal of Psychiatric Research*, *35*, 293–296.
Smart, D. W., & Smart, J. F. (1997). *DSM-IV* and culturally sensitive diagnosis: Some observations for counselors. *Journal of Counseling & Development*, *75*, 392–398. doi:10.1002/j.1556-6676.1997.tb02355.x
Wilson, M. (1993). *DSM-III* and the transformation of American psychiatry: A history. *The American Journal of Psychiatry*, *150*, 399–410.
World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: World Health Organization.
Zalaquett, C. P., Fuerth, K. M., Stein, C., Ivey, A. E., & Ivey, M. B. (2008). Reframing the *DSM-IV-TR* from a multicultural/social justice perspective. *Journal of Counseling & Development*, *86*, 364–371. doi:10.1002/j.1556-6678.2008.tb00521.x

DSM-5 Conceptual Changes: Innovations, Limitations and Clinical Implications

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The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) includes numerous alterations to specific disorders, as well as fundamental conceptual and organizational changes. The purpose of this article is to review three fundamental conceptual changes in *DSM-5*: the harmonization of the manual with the *International Statistical Classification of Diseases and Related Health Problems*, the introduction of spectrum disorders and dimensional ratings, and the new organization of the manual. For each change, potential benefits and shortcomings are discussed in terms of innovation, limitations and clinical implications.

Keywords: ***DSM-5*, *ICD-10*, classification, diagnosis, spectrum disorders**

The *DSM* is probably one of the most widely referenced texts in the mental health field. Considering this scope of influence, the release of its latest edition, *DSM-5* (American Psychiatric Association [APA], 2013), has garnered considerable interest among professionals, patient advocacy groups and the public alike (Paris, 2013). Reactions have ranged from enthusiastic support (McCarron, 2013) to concern (Welch, Klassen, Borisova, & Clothier, 2013) and even calls to reject the manual's use outright (Frances, 2013; Frances & Widiger; 2012). The strength of this reaction—both positive and negative—reflects the scope of change. *DSM-5* attempts to integrate almost 20 years of burgeoning research in psychopathology, classification and treatment outcomes that have emerged since the publication of *DSM-IV* (APA, 1994), the last major revision of the manual's criteria sets. While *DSM-5* has made numerous alterations to specific disorders, fundamental conceptual and organizational changes have had the most substantial impact on reshaping the manual (APA, 2013; Regier, Kuhl, & Kupfer, 2013).

The purpose of this article is to review three of these fundamental conceptual changes: the harmonization of the manual with the *ICD*, the introduction of spectrum disorders and dimensional ratings, and the new organization of the manual. For each of these innovations, three questions will be addressed. First, what was the basis for introducing the change as an innovation to the manual? Here the rationale and potential contribution of the change will be discussed. Special attention will be paid to issues such as enhanced diagnostic accuracy, coverage and clinical utility. Second, does the innovation have any potential drawbacks or limitations? For example, to what extent could the innovation contribute to over or underdiagnosis, limit access to treatment, or pose some harm like increased stigmatization? Third, what are the practical consequences of the innovation relative to how clinical mental health counselors provide care for their clients? This section considers the impact on day-to-day practice and how the diagnostic process itself may be transformed. The conclusion section ties these three threads of innovations together and discusses implications for mental health practice in the 21st century.

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DSM and *ICD* Harmony

There are two major classification systems for mental disorders: the *DSM*, used primarily in North America, and the *ICD*, used worldwide under the auspices of the World Health Organization (WHO). The *ICD* is a much broader classification encompassing causes of death, illness, injury and related health issues with one chapter dedicated to mental and behavioral disorders (Stein, Lund, & Nesse, 2013). As part of the United Nations Charter, countries around the world have agreed to use the *ICD* codes to report mortality, morbidity and other health information so that uniform statistics can be compiled. In the United States, the *ICD* codes are the official codes approved by the Health Insurance Portability and Accountability Act (HIPAA), which are used by insurance companies, Medicare, Medicaid and other health-related agencies (Goodheart, 2014). The code numbers that the *DSM* has always used are derived from whatever the official version of *ICD* is at that time. Currently, the ninth revision of the *ICD* (*ICD-9*; WHO, 1979) is the official coding system in the United States. The 10th revision of the *ICD* (*ICD-10*; WHO, 1992/2010) is scheduled to go into effect on October 1, 2015.

The *DSM* and *ICD* classifications of mental disorders have a number of similarities, but also have important differences. Both are *descriptive* classifications that categorize mental disorders based upon a constellation or *syndrome* of symptoms and signs. Symptoms are the client's reports of personal experiences such as feeling sad, anxious or worried. Signs, on the other hand, are observable client behaviors such as crying, rapid speech, and flat affect. Structurally, both manuals group related mental disorders into either chapters (*DSM*) or diagnostic blocks (*ICD*). The names and diagnostic descriptions for many of the mental disorders in the *ICD* are similar to those in the *DSM*, a consequence of collaboration over the years and a shared empirical pool from which both have drawn.

Despite these similarities, there are significant disparities. First, *DSM* criteria are very specific and detailed, while the *ICD* relies more on prototype descriptions with less detailed criteria and minimal background information to guide the diagnostic process (First, 2009; Paris, 2013; Stein et al., 2013; WHO, 1992). Second, since *DSM-III* (APA, 1980), the *DSM* has used a multiaxial system that notes not only relevant mental and medical disorders, but also other diagnostic information such as environmental factors (Axis IV) and level of functioning (Axis V). The *ICD*, on the other hand, has always employed a nonaxial system that simply lists medical disorders, mental disorders, and other health conditions. These differences in complexity reflect the constituencies that each manual is designed to serve: The *DSM* is primarily used by licensed mental health professionals with advanced degrees, while the *ICD* needs to be accessible to a range of health care professionals worldwide with a broad range of educational backgrounds (Kupfer, Kuhl, & Wulsin, 2013; WHO, 1992).

A third discrepancy is that the names and descriptions for many disorders differ, which at times reflects marked conceptual differences (First, 2009). For example, in *ICD-10* (WHO, 1992) bulimia nervosa has to be characterized by a "morbid dread of fatness" (p. 179), a concept akin to anorexia, while *DSM-IV-TR* (Text Revision; APA, 2000) requires that self-evaluation be "influenced" (p. 549) by only body shape or weight. As another example, the definition of the type of trauma that qualifies for post-traumatic stress disorder (PTSD) is much broader in *ICD-10* (allowing for events that are exceptionally threatening or catastrophic) than in *DSM-IV-TR* (requiring that the event must be associated with actual or threatened death, serious injury, or threat to the physical integrity). These *ICD-DSM* disparities have led to difficulties comparing research results, collecting health statistics, communicating diagnostic information and reaching similar diagnostic decisions (APA, 2013; First, 2009; Widiger, 2005). Like conversing in two different languages, the diagnosis has often been lost in translation.

Innovation

From the outset of the *DSM-5* development process there was a concerted effort to address these disparities. Joint meetings of representatives from APA and WHO met regularly throughout the process in an effort to make the manuals more compatible (APA, 2013; Regier et al., 2013). The goal was to find ways of harmonizing structural, conceptual and disorder-specific differences. The results of this process have had immediate effects on the look of *DSM-5* and will have long-term effects on the harmonization of *DSM-5* with the upcoming *ICD-11*, expected to be released in 2017 (APA, 2013; Goodheart, 2014).

The most significant impact of the harmonizing effort is the discontinuation of the multiaxial system in *DSM-5*. Axes I–III, the diagnostic axes (APA, 2000), are now collapsed into a nonaxial system, consistent with the *ICD* format. Psychosocial and environmental problems (formerly Axis IV) can be noted using *ICD-10*'s codes for problems and situations that influence health status or reasons for seeking care. These are usually referred to as *Z codes* and were formerly termed *V codes* in *DSM-IV-TR*. Axis V's Global Assessment of Functioning (GAF) has been removed and replaced by an *ICD* measure for disability, the World Health Organization Disability Assessment Schedule (WHODAS) 2.0 (APA, 2013). Unlike the GAF, however, this rating is not required and serves only as an ancillary tool.

The following is an example of how a *DSM-5* diagnosis might be listed using *ICD-9*'s nonaxial system in *ICD-9*:

296.42 Bipolar I disorder, current episode manic, moderate severity, with mixed features
307.83 Borderline personality disorder
V62.29 Other problem related to employment

The order of diagnoses would indicate that the bipolar disorder was the principal diagnosis and either the focus of treatment or reason for visit. In this example, borderline personality disorder is a secondary diagnosis. The V code is noted because it is an important area to target in the treatment plan.

There were three major reasons for abandoning the multiaxial system. First, health professionals in general medicine found it difficult to use because it was so different from the *ICD* format (Kupfer et al., 2013). Second, the multiaxial system contributed to the idea that mental disorders were qualitatively different from medical disorders, a dated dualistic distinction between mind and body (APA, 2013; Kupfer et al., 2013; Lilienfeld, Smith, & Watts, 2013). Third, research had shown that distinctions between Axes I and II were artificial and did not reflect that these axes actually overlapped considerably (Lilienfeld et al., 2013). Thus, the multiaxial system seemed to create artificial distinctions that did not seem valid (Lilienfeld et al., 2013). The *ICD*, on the other hand, offered a more simplified system that allowed a diverse group of health professionals to code disorders using a similar format.

Substantial harmonization of the manuals, however, will happen in the future. Not much could be done with harmonizing *ICD-10* (WHO, 1992), a manual of the *DSM-IV* (APA, 1994) era, the organization and conceptual framework of which were well established (APA, 2013; Goodheart, 2014). The forthcoming *ICD-11* will adopt much of *DSM-5*'s organizational restructuring (discussed below) and include a number of the new *DSM-5* disorders (APA, 2013; Goodheart, 2014).

Limitations

Despite the potential contribution of this harmonization, there are three major drawbacks to consider. First, the loss of the multiaxial system may compromise the richness of the diagnostic assessment. In a sense, the

multiaxial system was holistic in that it provided a way of noting prominent psychiatric conditions, maladaptive personality functioning, medical conditions, relevant stressors and environmental problems, and overall functioning. What will prompt clinicians to consider these important domains remains unclear. Noting V codes and assessing disability using the WHODAS 2.0 may be an alternative. However, these tasks are not required in the diagnostic workup and, if history is any guide, will probably be underutilized.

A second consideration is that consilience with the *ICD* clearly makes the *DSM-5* a "medical classification" (APA, 2013, p. 10) and as David Kupfer, the Task Force Chair of *DSM-5*, has put it, "psychiatric disorders *are* medical disorders" (Kupfer et al., 2013, p. 388). The *DSM* espouses that it is atheoretical (APA, 2013; Lilienfeld et al., 2013), but the momentum is clearly swinging toward the central role of biological factors. This risks a reductionistic conceptualization of mind as simply brain. Alternative perspectives that recognize the importance of contextual, psychological, developmental and cultural factors, fundamental to the mental health counseling tradition (Gintner & Mears, 2009), may suffer as a result. The picture is more ominous considering the National Institute of Mental Health's initiative, Research Domain Criteria (RDoC), designed to develop the next generation of psychiatric classification based upon underlying etiology of "brain disorders" (p. 749) and the identification of biomarkers (e.g., laboratory tests) to direct treatment selection (Insel et al., 2010). The direction in which the diagnostic train is heading is clear. The question is whether the track can be altered to one that is more balanced and biopsychosocial.

A third concern is that efforts to harmonize the manuals do not address many of the disparities between *DSM-5* and *ICD-9* or *ICD-10*. This is particularly true of the new disorders that *DSM-5* has added, which lack clear *ICD-9* or *ICD-10* counterparts. The *ICD* codes that have been selected often do not map well onto these disorders. For example, the code for *DSM-5*'s hoarding disorder translates to *ICD-9*'s and *ICD-10*'s obsessive-compulsive disorder (OCD). Ironically, hoarding disorder was added because research showed that 80% of the time individuals with this condition did not meet criteria for OCD. As another example, binge eating disorder was added to *DSM-5* to recognize individuals who had a pattern of maladaptive bingeing episodes, but did not have the compensatory behaviors (e.g., purging) characteristic of bulimia nervosa. The *ICD* code selected for this disorder was, nevertheless, bulimia nervosa. Because *ICD* is updated annually, it may be that more appropriate codes will be made available in future years. Thus, while *ICD-DSM* consilience has occurred, at least to this point, it has been superficial and restricted to the nonaxial formatting of the diagnosis. Clearly, it may enhance the curb appeal of *DSM-5* to the medical community, but the real interior renovation is yet to occur, awaiting *ICD-11*.

Clinical Implications

The demise of the multiaxial system means that mental health counselors must be more intentionally biopsychosocial in their diagnostic assessments. More meat can be put on the bare-bones nonaxial system by systematically assessing these biological, psychological and sociocultural factors. This can be accomplished by always assessing whether any important contextual factors can be noted using the V codes, which will be termed *Z codes* when *ICD-10* goes into effect. The WHODAS 2.0, the retired GAF, and other functioning measures can be recruited to assess impairment. While these measures are not part of the formal diagnosis, they can be noted in the chart and inform treatment planning.

Many insurance companies require a multiaxial diagnosis. The GAF score was often used to justify level of care. At the time of this writing, it is not clear what insurance companies will do with these modifications. The decision here will be important. What insurance companies require, for better or worse, often has profound impact on what clinicians do and the kind of clinical care they deliver.

Spectrum Disorders and Dimensionality

Both the *DSM* and *ICD* classify mental disorders into discrete categories. Clinicians make a yes-no decision about whether or not an individual has a disorder, based upon the particular criteria. But it has long been known that this categorical approach is fraught with problems (First & Westen, 2007; Widiger, 2005). First, comorbidity is common and there is some question as to whether comorbid conditions such as depression and anxiety are distinct or are really different expressions of some shared underlying dysfunction (Lilienfeld et al., 2013). Second, clinicians have used the *not otherwise specified* (NOS) category 30–50% of the time, indicating that a sizable proportion of phenomena have a varied presentation that existing categories do not capture (Widiger, 2005). This is problematic because NOS is not particularly informative in terms of describing the condition or making decisions about treatments. Finally, a categorical system assumes that each disorder is homogenous and that *disorder* occurs at the particular cut point. There is no recognition of subthreshold symptoms, and there is the assumption that those who do fulfill the criteria are qualitatively similar. This view is at odds with data showing that symptoms vary considerably in terms of severity and accompanying features (First & Tasman, 2004). In this sense, categorical assignment loses potentially useful clinical information about the condition and about what treatment strategies might be indicated.

Innovation

DSM-5 attempts to address this issue by introducing dimensionality to supplement the categorical approach (APA, 2013). While categories indicate differences in *kind*, dimensions describe variations in *degree* (Lilienfeld et al., 2013). From this perspective, mental disorders are considered to lie on a continuum, like blood pressure. Theoretically, the spectrum can run from optimal functioning to significant impairment. Markers of morbidity or adverse outcome determine where on the spectrum the cut point for *disorder* is drawn. In the case of blood pressure, for example, it is 140/90. This dimensionality allows for more fine-grained determination of not only severity or impairment, but also improvement or deterioration. Over the past 30 years, research has shown that many mental disorders appear to be more dimensional and heterogeneous than suggested by *ICD*'s or *DSM*'s purely categorical system (First & Westen, 2007; Helzer, 2011; Paris, 2013).

Dimensionality is incorporated into *DSM-5* in three general ways. First, *DSM-5* has added several formal spectrum disorders, which combine highly related disorders. Autism spectrum disorder merges together *DSM-IV-TR's* autism disorder, Asperger's disorder, childhood disintegrative disorder and pervasive developmental disorder NOS. Research has shown that these four conditions share many common symptoms, and the differences are more a matter of degree (APA, 2013; Tsai & Ghaziuddin, 2014). Another spectrum disorder is substance use disorder, which blends the former categories of abuse and dependence. The somatic spectrum is captured by somatic symptoms disorder, which merges what was formerly somatization disorder, pain disorder and undifferentiated somatoform disorder. For each of these spectrum disorders, *DSM-5* provides a severity rating as well as other specifiers to note degree of impairment and complicating features.

A second way that dimensionality is infused into *DSM-5* is that severity ratings and an expanded list of specifiers have been placed within the existing categories. In a sense, *DSM-5* tries to dimensionalize the category. While this was done to some extent in previous editions, *DSM-5* broadens this effort throughout the manual. For example, a number of new specifiers were added to describe mood episodes such as *anxious distress* (presence of comorbid anxiety), *mixed features* (presence of symptoms from the opposite mood pole), and *peripartum onset* (onset of symptoms sometime during pregnancy through one month post-delivery). The addition of these notations can be helpful in making treatment-planning decisions (First & Tasman, 2004). For example, severity ratings are an important consideration in deciding whether to use psychotherapy or

medication for the treatment of major depressive disorder (APA, 2010). Feature specifiers like *anxious distress* and *mixed features* have been shown to increase suicide risk and portend a more complicated treatment regime (APA, 2013; Vieta & Valentí, 2013).

A third way that dimensionality is being promoted in *DSM-5* is through the availability of a variety of online assessment measures (APA, 2014). These are rating scales that fall into three general categories. First, there are disorder-specific measures that correspond closely to the diagnostic criteria. These measures could be used to buttress the more clinical assessment that relies on the diagnostic criteria. They could also provide a means of assessing the client's baseline and response to treatment over time. Measures are available for a range of disorders including depression, many of the anxiety disorders, PTSD, acute stress disorder and dissociative symptoms. Versions are available for adults as well as children aged 11–17. Most of these are self-completed but some are clinician-rated. A second type of measure is the WHODAS 2.0, discussed earlier, which assesses domains of disability in adults 18 and older. A third type of measure is referred to as cross-cutting symptom measures (CCSM). Similar to a broadband assessment of bodily systems in medicine, these measures assess common psychiatric symptoms that may present across diagnostic boundaries and may be clinically significant to note in the overall treatment plan. Level 1 CCSM is a brief survey of 13 domains of symptoms (e.g., depression, anxiety, psychosis, obsessions, mania). A more in-depth Level 2 assessment measure is available for a domain that indicates a significantly high rating. These measures can be reproduced and used freely by researchers and clinicians and can be downloaded at http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures. Use of these types of measure is hoped to add surplus information that can aid diagnosis, case monitoring and treatment planning.

Limitations

Dimensions are not only intuitively appealing, but also seem to be a better reflection of nature (Lilienfeld et al., 2013). Notwithstanding, serious concerns have been raised. First, determining the appropriate cut point on these dimensions is critical in terms of determining true psychopathology. If the bar is set too low, there is a danger of pathologizing normal behavior. If set too high, those who need treatment may be excluded and denied services. At this point, data suggest that at least for autism spectrum disorder and substance use disorder, the bar might be set too high. For both, *DSM-5* criteria tend to miss people on the more benign end of the spectrum. For example, those who formerly might have been diagnosed with mild to moderate Asperger's, pervasive developmental disorder NOS, or substance abuse may no longer qualify for a diagnosis (Beighley et al., 2013; Mayes, Black, & Tierney, 2013; Peer et al., 2013; Proctor, Kopak, & Hoffmann, 2013). On the other hand, Frances (2013) has suggested that the threshold for somatic symptoms disorder is set too low, pathologizing many with normal worry about their medical illnesses.

A second concern is that lumping mild and more severe disorders into a unitary spectrum disorder can have unintended social effects, especially for people on the more benign end of the spectrum. For example, those who formerly were diagnosed with Asperger's disorder will now be labeled with autism spectrum disorder. A college student who was diagnosed with alcohol abuse using *DSM-IV-TR* criteria will now carry the same diagnosis as someone who is considered an alcoholic and dependent (Frances, 2013). One unanswered question is the impact of these types of name changes on perceived stigma and consequent help seeking.

A final concern is that the dimensional measures were released prematurely without adequate testing and without sufficient guidelines for their use (Jones, 2012; Paris, 2013). While some of the measures are well established (e.g., Patient Health Questionnaire [PHQ]-9; APA, 2014), others have little to no psychometric support (e.g., Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders). Scoring guidelines are made available, but information about the measure's psychometric properties and norming are lacking. There also is no information on who is qualified to use these measures and what type of training

they should have. Thus, while dimensionality may be an important innovation in the development of the *DSM* classification system, there are significant challenges ahead in calibrating these dimensions, refining the measures and considering social consequences.

Clinical Implications

Will dimensionality help or hinder the diagnostic process? On one level, the additional information about the condition may shift counselors' fundamental way of thinking about treatment from "curing" clients (dichotomous) to helping them move toward more optimal points on the spectrum (dimensional). The availability of dimensional measures has the potential of improving diagnostic accuracy and providing a measure of treatment outcome (Segal & Coolidge, 2007). It may open the door to more measurement-based care, in which these ratings can be used to assess more precisely the need for care and the extent to which clients are profiting from treatment. This process may be more feasible to administer, score and record if these measures can be stored on tablets or mobile applications.

In terms of using these dimensional measures, however, the unanswered question is—at what cost? Clinicians are already busy, and anything that encumbers that process even more will be resisted (Paris, 2013). Criteria sets are now a bit more complex to navigate because of the added severity rating and feature specifiers. It will take considerable time to learn and master the range of measures that have been posted online, much less research their psychometric appropriateness for the situations in which they will be used. The wild card is whether managed care will require these types of measures as a way of documenting need for treatment and response to provided services. At this point, clinicians would be best served to proceed cautiously, ensuring that the measures they use are reliable and valid for the client population intended.

The New Organization of *DSM-5*

How was it decided in previous editions of the *DSM* which chapters to include and which disorders to place in each of them? While some research guided this process, tradition and clinical consensus were the primary sources that informed the organization of these earlier manuals (First & Tasman, 2004; Regier et al., 2013; Widiger, 2005). *DSM-5* took a radically different approach, drawing upon research that examined how disorders actually cluster together. In this section, the new framework is examined and potential benefits and costs discussed.

Innovation

The *DSM-5* manual is divided into three major sections. Section I provides an introduction, a discussion of key concepts such as the definition of a mental disorder, and guidelines for recording a diagnosis. Section II is the meat of the manual and contains all the mental disorders and other conditions that can be coded with their diagnostic criteria and background information. Section III includes tools for enhancing the diagnostic process, such as some of the dimensional measures discussed earlier, the WHODAS 2.0, and a Cultural Formulation Interview designed to assess the impact of culture on the clinical presentation. This section also includes a list of proposed mental disorders that require further study (e.g., Internet gaming disorder) and an alternative system for diagnosing personality disorders.

Table 1 lists *DSM-5*'s major categories (chapters) of mental disorders. Two general principles determined the sequence of chapters and the placement of disorders within chapters. First, disorders were grouped into similar clusters based upon shared underlying vulnerabilities, risk factors, symptoms presentation, course and response to treatment (APA, 2013). Groups that are positioned next to each other share more commonalities than those placed further apart. For example, bipolar disorder follows schizophrenia spectrum because they share a number

of vulnerability factors (APA, 2013). Next to bipolar disorder is the chapter on depressive disorders. However, the sequence of chapters indicates that depressive disorders are more distantly related to schizophrenia spectrum. Next, internalizing disorders characterized by depression, anxiety and somatic symptoms are listed in adjacent chapters because of common risk factors, treatment response and comorbidity (APA, 2013). Externalizing disorders, noted by their impulsivity, acting out and substance use, are placed in the latter part of the manual.

Table 1

DSM-5 *Classification*

Sequence of Chapters in Section II
Neurodevelopmental Disorders
Schizophrenia Spectrum and Other Psychotic Disorders
Bipolar and Related Disorders
Depressive Disorders
Anxiety Disorders
Obsessive-Compulsive and Related Disorders
Trauma- and Stressor-Related Disorders
Dissociative Disorders
Somatic Symptom and Related Disorders
Feeding and Eating Disorders
Elimination Disorders
Sleep-Wake Disorders
Sexual Dysfunctions
Gender Dysphoria
Disruptive, Impulse Control, and Conduct Disorders
Substance-Related and Addictive Disorders
Neurocognitive Disorders
Personality Disorders
Paraphilic Disorders
Other Mental Disorders
Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Other Conditions That May Be a Focus of Clinical Attention

This shared commonality principle is also evident in the placement of disorders within chapters. As a result, a number of disorders have been transferred to different chapters. For example, *DSM-IV-TR*'s chapter on sexual and gender identity disorders contained sexual dysfunctions (e.g., premature ejaculation), paraphilias (e.g., exhibitionism) and gender identity disorder. Research showed that these three were not highly related, so they have been moved into different chapters, each of which is more proximally located to related disorders (APA, 2013). As another example, *DSM-IV-TR*'s anxiety disorders chapter has been divided into three separate chapters: anxiety disorders that are more fear-based (e.g. phobias); obsessive-compulsive and related disorders, which are characterized by preoccupations and repetitive behaviors (e.g., body dysmorphic disorder); and trauma- and stressor-related disorders. The latter is akin to a stress-response spectrum that ranges from severe reactions like PTSD to milder reactions characteristic of an adjustment disorder. It is hoped that these organizational changes will help clinicians locate disorders as well as identify related comorbidities (APA, 2013).

A second organizational principle is that the *DSM-5* framework reflects a life-span perspective, both across and within chapters. Neurodevelopmental disorders (e.g., autism spectrum disorder, attention-deficit/hyperactivity disorder [ADHD]) are listed first because they typically emerge early in life. Schizophrenia spectrum disorders also frequently have antecedents that manifest themselves in childhood (APA, 2013). Next are disorders that usually appear in adolescence and early adulthood, such as bipolar disorders, depressive disorders and anxiety disorders. In the middle and back of the manual are disorders that emerge in adulthood or late adulthood, such as personality disorders and neurocognitive disorders (e.g., dementia related to Alzheimer's disease).

A developmental perspective also is infused into the organization of each chapter. *DSM-IV-TR*'s chapter on disorders of infancy, childhood and adolescence has been eliminated, and these disorders have been redistributed throughout the manual into relevant chapters. Each chapter is developmentally organized with disorders that emerge in childhood listed first, followed by those that appear in adolescence and adulthood. For example, oppositional defiant disorder and conduct disorder have been moved to the beginning of the chapter on disruptive, impulse control and conduct disorders. In addition, the criteria sets now include developmental manifestations of symptoms. For example, the ADHD criteria set includes both child and adult examples of the various symptoms. There also is an expanded section on development and course for each of the disorders, which explains how symptoms typically unfold over the life span. It is hoped that these types of changes will help clinicians recognize age-related manifestations of symptomatology (Kupfer et al., 2013; Pine et al., 2011).

The intent of the *DSM-5* initiative was to develop a more valid organizational structure grounded in research. In the end it also may help to uncover common etiological factors—the holy grail of classification efforts (Insel et al., 2010; Stein et al., 2013). Certainly, these changes will help with differential diagnosis. The organization provides a better map of the relationship between disorders and how the diagnostic landscape may change over the life span.

Limitations

The new organization of the *DSM-5* has been generally well received (Stein et al., 2013). One major concern that has been raised, however, is the decision to dismantle the chapter on child and adolescent disorders (Pine et al., 2011). Now there is not one place where the range of childhood disorders is listed. The neurodevelopment disorders—the remnant of the former child and adolescent chapter—is largely limited to disorders that manifest with early developmental delays and problems with language, learning, motor behavior, thinking or attention. Missing, however, are a broader range of behavior problems and anxiety disorders that the former chapter included. The problem is that many of these disorders can co-occur. For example, about 30–50% of children with conduct disorder have a specific learning disorder (Gintner, 2000). The wide separation of conditions such as these in the manual may interfere with accurate detection, especially among those who are not familiar with child and adolescent disorders.

Clinical Implications

Mental health counselors have a new organization to master. Anecdotally, probably one of the most common comments I hear about the new manual is, "Where do I find X now?" Understanding the new organization of the manual will require more than simply looking over the new structure. It will be critical to read the manual to understand why disorders were grouped in a particular chapter. Chapters that are either newly introduced in the manual or that were significantly altered will certainly need to be carefully reviewed. These include the chapters on neurodevelopmental disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, substance-related and addictive disorders, and neurocognitive disorders.

Importantly, the new *DSM-5* message is that the structure is designed to indicate relationships within chapters and between chapters. This is a different way of thinking diagnostically. For example, in considering possible diagnostic alternatives, the clinician can first ask this broad question: Is this on the internalizing or externalizing spectrum? If the condition seems more internalizing, then the possible chapters have been winnowed down, and progressively more specific questions can be asked to locate the disorder in the particular chapter. The organization also alerts the diagnostician that adjacent chapters may hold comorbid conditions or even unexplained subthreshold symptoms. To take advantage of this diagnostic aid, however, it will be critical for mental health counselors to learn their way around this new framework.

Conclusions

These conceptual changes define the new look of *DSM-5*. *ICD*'s consilience, dimensionality and the organizational restructuring have fundamentally transformed *DSM-5* into a 21st-century document that reflects the current state of knowledge in the mental health profession. The good news is that these changes may make the manual a better reflection of nature (i.e., research has shown it to be more valid) compared to previous editions. As a result, the way counselors diagnose and how they think about mental disorders is changing. Hopefully, such change will not only result in better care, but will also help researchers identify the deeper etiological substrates of mental disorders.

In science, progress also can have a dark side. While the *DSM-5* incorporates the latest research, the entire development process and critical review highlight the primitive state of knowledge in the profession. While the spectrums and dimensions will no doubt transform the way mental health professionals diagnose, at this point they are crude and may help certain client populations, but hurt others. Harmonization with the *ICD* will probably take the *DSM-5* to a broader audience of health providers. But it also further medicalizes the *DSM-5* and will steer it perilously close to a biologically-based classification system. It will be up to mental health counselors and allied mental health professionals to help correct the course and find the middle way exemplified in the biopsychosocial model. Until then, *DSM-5*'s advances will be tempered by these potential limitations.

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References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2010). *Practice guideline for the treatment of patients with major depressive disorder* (3rd ed.). Retrieved from http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1667485

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from

http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Beighley, J. S., Matson, J. L., Rieske, R. D., Jang, J., Cervantes, P. E., & Goldin, R. L. (2013). Comparing challenging behavior in children diagnosed with autism spectrum disorders according to the *DSM-IV-TR* and the proposed *DSM-5*. *Developmental Neurorehabilitation*, *16*, 375–381. doi:10.3109/17518423.2012.760119

First, M. B. (2009). Harmonisation of ICD–11 and DSM–V: Opportunities and challenges. *The British Journal of Psychiatry*, *195*, 382–390. doi:10.1192/bjp.bp.108.060822

First, M. B., & Tasman, A. (2004). *DSM-IV-TR mental disorders: Diagnosis, etiology & treatment*. Chichester, England: John Wiley & Sons.

First, M. B., & Westen, D. (2007). Classification for clinical practice: How to make ICD and DSM better able to serve clinicians. *International Review of Psychiatry*, *19*, 473–481. doi:10.1080/09540260701563429

Frances, A. (2013). *Essentials of psychiatric diagnosis: Responding to the challenge of DSM-5*. New York, NY: Guilford Press.

Frances, A. J., & Widiger, T. (2012). Psychiatric diagnosis: Lessons from the DSM-IV past and cautions for the DSM-5 future. *Annual Review of Clinical Psychology*, *8*, 109–130.

Gintner, G. G. (2000). Conduct disorder and chronic violent offending: Issues in diagnosis and treatment selection. In D. S. Sandhu & C. B. Aspy (Eds.), *Violence in American schools: A practical guide for counselors* (pp. 335–351). Alexandria, VA: American Counseling Association.

Gintner, G. G., & Mears, G. (2009). Mental health counseling. In W. G. Emener, M. A. Richard, & J. J. Bosworth. (Eds.), *A guidebook to human service professions: Helping college students explore opportunities in the human services field* (2nd ed., pp. 154–165). Springfield, IL: Charles C. Thomas.

Goodheart, C. D. (2014). *A primer for ICD-10-CM users: Psychological and behavioral conditions*. Washington, DC: American Psychological Association.

Helzer, J. E. (2011). A proposal for incorporating clinically relevant dimensions into DSM-5. In D. A. Regier, W. E. Narrow, E. A. Kuhl, & D. J. Kupfer (Eds.), *The conceptual evolution of DSM-5* (pp. 81–96). Washington, DC: American Psychiatric Association.

Insel, T., Cuthbert, B., Garvey, M., Heinssen, R., Pine, D. S., Quinn, K., . . . Wang, P. (2010). Research domain criteria (RDoC): Toward a new classification framework for research on mental disorders. *The American Journal of Psychiatry*, *167*, 748–751. doi:10.1176/appi.ajp.2010.09091379

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling and Development*, *90*, 481–487. doi:10.1002/j.1556-6676.2012.00059.x

Kupfer, D. J., Kuhl, E. A., & Wulsin, L. (2013). Psychiatry's integration with medicine: The role of DSM-5. *Annual Review of Medicine*, *64*, 385–392. doi:10.1146/annurev-med-050911-161945

Lilienfeld, S. O., Smith, S. F., & Watts, A. L. (2013). Issues in diagnosis: Conceptual issues and controversies. In W. E. Craighead, D. J. Miklowitz, & L. W. Craighead (Eds.), *Psychopathology: History, diagnosis, and empirical foundations* (2nd ed., pp. 1–35). Hoboken, NJ: John Wiley & Sons.

Mayes, S. D., Black, A., & Tierney, C. D. (2013). DSM-5 under-identifies PDDNOS: Diagnostic agreement between the DSM-5, DSM-IV, and checklist for autism spectrum disorder. *Research in Autism Spectrum Disorders*, *7*, 298–306. doi:10.1016/j.rasd.2012.08.011

McCarron, R. M. (2013). The DSM-5 and the art of medicine: Certainly uncertain. *Annals of Internal Medicine*, *159*, 360–361. doi:10.7326/0003-4819-159-7-201310010-00688

Paris, J. (2013). *The intelligent clinician's guide to the DSM-5*. New York, NY: Oxford University Press.

Peer, K., Rennert, L., Lynch, K. G., Farrer, L., Gelernter, J., & Kranzler, H. R. (2013). Prevalence of DSM-IV and DSM-5 alcohol, cocaine, opioid, and cannabis use disorders in a largely substance dependent sample. *Drug & Alcohol Dependence*, *127*, 215–219. doi:10.1016/j.drugalcdep.2012.07.009

Pine, D. S., Costello, E. J., Dahl, R., James, R., Leckman, J. F., Leibenluft, E., . . . Zeanah, C. H. (2011). Increasing the developmental focus in DSM-5: Broad issues and specific potential applications in anxiety. In D. A. Regier, W. E. Narrow, E. A. Kuhl, & D. J. Kupfer (Eds.), *The conceptual evolution of DSM-5* (pp. 305–321). Washington, DC: American Psychiatric Publishing.

Proctor, S. L., Kopak, A. M., & Hoffmann, N. G. (2013). Cocaine use disorder prevalence: From current DSM-IV to proposed DSM-5 diagnostic criteria with both a two and three severity level classification system. *Psychology of Addictive Behaviors*. Advance Online Publication. doi:10.1037/a0033369

Regier, D. A., Kuhl, E. A., & Kupfer, D. J. (2013). The DSM-5: Classification and criteria changes. *World Psychiatry*, *12*,

92–98. doi:10.1002/wps.20050

Segal, D. L., & Coolidge, F. L. (2007). Structured and semistructured interviews for differential diagnosis: Issues and applications. In M. Hersen, S. M. Turner, & D. C. Beidel (Eds.), *Adult psychopathology and diagnosis* (5th ed., pp. 79–100). Hoboken, NJ: John Wiley & Sons.

Stein, D. J., Lund, C., & Nesse, R. M. (2013). Classification systems in psychiatry: Diagnosis and global mental health in the era of DSM-5 and ICD-11. *Current Opinion in Psychiatry*, *26*, 493–497. doi:10.1097/YCO.0b013e3283642dfd

Tsai, L. Y., & Ghaziuddin, M. (2014). DSM-5 ASD moves forward into the past. *Journal of Autism and Developmental Disorders*, *44*, 321–330. doi:10.1007/s10803-013-1870-3

Vieta, E., & Valentí, M. (2013). Mixed states in *DSM-5*: Implications for clinical care, education, and research. *Journal of Affective Disorders*, *148*, 28–36. doi:10.1016/j.jad.2013.03.007

Welch, S., Klassen, C., Borisova, O., & Clothier, H. (2013). The *DSM-5* controversies: How should psychologists respond? *Canadian Psychology*, *54*, 166–175. doi:10.1037/a0033841

Widiger, T. A. (2005). Classification and diagnosis: Historical development and contemporary issues. In J. E. Maddux & B. A. Winstead (Eds.), *Psychopathology: Foundations for contemporary understanding* (pp. 69–91). Mahwah, NJ: Lawrence Erbaum Associates.

World Health Organization. (1979). *International statistical classification of diseases and related health problems* (9th rev.). Geneva, Switzerland: Author.

World Health Organization. (1992). *International statistical classification of diseases and related health problems* (10th rev.). Geneva, Switzerland: Author.

World Health Organization. (2010). *International statistical classification of diseases and related health problems* (10th rev.). Retrieved from http://apps.who.int/classifications/icd10/browse/2010/en

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 (Ustün, Kostanjsek, Chatteriji, & 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. Ustün 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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References

Aas, I. H. M. (2010). Global Assessment of Functioning (GAF): Properties and frontier of current knowledge. *Annals of General Psychiatry*, *9*, 20. doi:10.1186/1744-859X-9-20

Aas, I. H. M. (2011). Guidelines for rating Global Assessment of Functioning (GAF). *Annals of General Psychiatry*, *10*, 2. doi:10.1186/1744-859X-10-2

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2012). *Definition of a mental disorder.* Retrieved from http://www.dsm5.org/Pages/Default.aspx

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2014). *Online assessment measures.* Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Bacon, S. F., Collins, M. J., & Plake, E. V. (2002). Does the Global Assessment of Functioning assess functioning? *Journal of Mental Health Counseling*, *24*, 202–212.

Ben-Zeev, D., Young, M. A., & Corrigan, P. W. (2010). DSM-V and the stigma of mental illness. *Journal of Mental Health*, *19*, 318–327. doi:10.3109/09638237.2010.492484

Bhugra, D., & Kalra, G. (2010). Cross cultural psychiatry: Context and issues. *Journal of Pakistan Psychiatric Society*, *7*, 51–54.

Castillo, R. J. (1997). *Culture & mental illness: A client-centered approach.* Pacific Grove, CA: Brooks/Cole.

Dailey, S. F., Gill, C. S., Karl, S. L., & Barrio Minton, C. A. (2014). *DSM-5 learning companion: A guide for counselors*. Alexandria, VA: American Counseling Association.

Eriksen, K., & Kress, V. E. (2005). *Beyond the DSM story: Ethical quandaries, challenges, and best practices*. Thousand Oaks, CA: Sage.

Eriksen, K., & Kress, V. E. (2006). The DSM and professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling*, *28*, 202–217.

First, M. B. (2010). Paradigm shifts and the development of the diagnostic and statistical manual of mental disorders: Past experiences and future aspirations. *The Canadian Journal of Psychiatry*, *55*, 692–700.

Frances, A. (2013). *Essentials of psychiatric diagnosis: Responding to the challenge of DSM-5.* New York, NY: Guilford Press.

Gilman, S. E., Trinh, N.-H., Smoller, J. W., Fava, M., Murphy, J. M., & Breslau, J. (2013). Psychosocial stressors and the prognosis of major depression: A test of Axis IV. *Psychological Medicine*, *43*, 303–316. doi:10.1017/S0033291712001080

Hansen, J. T. (2009). On displaced humanists: Counselor education and the meaning–reduction pendulum. *Journal of Humanistic Counseling, Education and Development*, *48*, 65–76. doi:10.1002/j.2161-1939.2009.tb00068.x

Hilsenroth, M. J., Ackerman, S. J., Blagys, M. D., Baumann, B. D., Baity, M. R., Smith, S. R., . . . Holdwick, D. J., Jr. (2000). Reliability and validity of DSM-IV axis V. *The American Journal of Psychiatry*, *157*, 1858–1863. doi:10.1176/appi.ajp.157.11.1858

Ivey, A. E., & Ivey, M. B. (1999). Toward a developmental diagnostic and statistical manual: The vitality of a contextual framework. *Journal of Counseling & Development*, *77*, 484–490. doi:10.1002/j.1556-6676.1999.tb02476.x

Jones, K. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development*, *90*, 481–487. doi:10.1002/j.1556-6676.2012.00059.x

Kress, V. E., Hoffman, R. M., & Eriksen, K. (2010). Ethical dimensions of diagnosing: Considerations for clinical mental health counselors. *Counseling and Values*, *55*, 101–112. doi:10.1002/j.2161-007X.2010.tb00024.x

Kress, V. E., & Paylo, M. J. (2014). *Treating those with mental disorders: A comprehensive approach to case conceptualization and treatment*. Columbus, Ohio: Pearson.

Kress, V. E., Paylo, M., Adamson, N., & Baltrinic, E. (in press). Teaching diagnosis in context: Guided imagery as a contextually sensitive pedagogical technique. *Journal of Creativity in Mental Health.*

Kulnik, S. T., & Nikoletou, D. (2014). WHODAS 2.0 in community rehabilitation: A qualitative investigation into the validity of a generic patient-reported measure of disability. *Disability and Rehabilitation*, *36*, 146–154. doi:10.3109/09638288.2013.782360

Kupfer, D. J., & Regier, D. A. (2011). Neuroscience, clinical evidence, and the future of psychiatric classification in DSM-5. *The American Journal of Psychiatry*, *168*, 672–674.

Miller, R., & Prosek, E. A. (2013). Trends and implications of proposed changes to the *DSM-5* for vulnerable populations. *Journal of Counseling & Development*, *91*, 359–366. doi:10.1002/j.1556-6676.2013.00106.x

Probst, B. (2014). The life and death of axis IV: Caught in the quest for a theory of mental disorder. *Research on Social Work Practice*, *24*, 123–131. doi:10.1177/1049731513491326

Ro, E., & Clark, L. A. (2009). Psychosocial functioning in the context of diagnosis: Assessment and theoretical issues. *Psychological Assessment*, *21*, 313–324. doi:10.1037/a0016611

Røysamb, E., Kendler, K. S., Tambs, K., Ørstavik, R. E., Neale, M. C., Aggen, S. H., . . . Reichborn-Kjennerud, T. (2011). The joint structure of DSM-IV Axis I and Axis II disorders. *Journal of Abnormal Psychology*, *120*, 198–209. doi:10.1037/a0021660

Schorre, B. E. H., & Vandvik, I. H. (2004). Global assessment of psychosocial functioning in child and adolescent psychiatry: A review of three unidimensional scales (CGAS, GAF, GAPD). *European Child & Adolescent Psychiatry*, *13*, 273–286. doi:10.1007/s00787-004-0390-2

Ustün, T. B., Kostanjsek, N., Chatterji, S., & Rehm, J. (Eds.). (2010). *Measuring health and disability: Manual for WHO Disability Assessment Schedule (WHODAS 2.0)* [Online version]. Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/publications/2010/9789241547598_eng.pdf

Yang, L. H., Wonpat-Borja, A. J., Opler, M. G., & Corcoran, C. M. (2010). Potential stigma associated with inclusion of the psychosis risk syndrome in the DSM-V: An empirical question. *Schizophrenia Research*, *120*, 42–48. doi:10.1016/j.schres.2010.03.012

Zalaquett, C. P., Fuerth, K. M., Stein, C., Ivey, A. E., & Ivey, M. B. (2008). Reframing the *DSM-IV-TR* from a multicultural/social justice perspective. *Journal of Counseling & Development*, *86*, 364–371. doi:10.1002/j.1556-6678.2008.tb00521.x

Clinical Application of the *DSM-5* in Private Counseling Practice

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; APA, 2013) continues its 60-year legacy as a standard reference for clinical practice in the mental health field. Six mental health disorders are reviewed with a focus on changes between the *DSM-IV-TR* and the *DSM-5* that represent the new landscape for each of these disorders, respectively. Following the summary of changes, a clinical scenario is presented so that counselors can capture the vision of using the *DSM-5* in their counseling practice. Clinical formulation (sample diagnosis) using the *DSM-5* is also presented for each disorder classification.

***Keywords: DSM-5*, *DSM-IV-TR*, private practice, clinical formulation, mental disorders**

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; APA, 2013) continues its 60-year legacy as a standard reference for clinical practice in the mental health field. This practical, functional and flexible guide is intended for use by trained counselors in a wide diversity of contexts and facilitates a common language to communicate the necessary characteristics of mental disorders present in their clients (APA, 2013). As counselors use the *DSM-5*, they will notice an expanded discussion of developmental and life span considerations, cultural issues, gender differences, integration of scientific findings from the latest research in genetics and neuroimaging, and enhanced use of course, descriptive and severity specifiers for diagnostic precision (APA, 2013). They will also notice a dimensional approach to diagnosis, consolidation and restructuring of most mental disorders; a new definition of a mental disorder; and emerging assessments and monitoring tools so as to promote enhanced clinical case formulation.

The intent of this article is to assist all counseling specialists by presenting six clinical scenarios from the author's counseling practice. The article begins by summarizing the clinical utility of the *DSM-5* and provides recommendations for counselors on how to sequence their study of the new manual. Discussed next are use of the new emerging assessment measures, autism spectrum disorder, schizophrenia spectrum and other psychotic disorders, sleep-wake disorders, neurocognitive disorders, and comorbid conditions such as excoriation (skin-picking) disorder and post-traumatic stress disorder—with a focus on prominent changes between the *DSM-IV-TR* and the *DSM-5*. Clinical formulation and its associated rationale using the *DSM-5* are presented for each disorder classification.

Counselors are encouraged to read the full manual and to especially read the Preface; Section I (i.e., Introduction, Use of the Manual, and Cautionary Statement for Forensic Use of *DSM-5*); Section III: Emerging Measures and Models (i.e., Assessment Measures); and Appendix (i.e., Highlights of Changes From *DSM-IV* to *DSM-5*) before they attempt applied clinical use of the manual. To appreciate the rationale for the *DSM-5* changes, counselors are encouraged to read the *DSM-IV-TR* discussion on limitations to the categorical approach (APA, 2000, pp. xxxi–xxxii) and on the nonaxial format (p. 37). This sequencing of study will help

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counselors use the manual as intended and avoid diagnostic errors, as well as maintain cultural sensitivity and avoid historical and social prejudices in the diagnosis of pathology (ACA, 2014).

Cross-Cutting Symptom Measures and Disorder-Specific Severity Measures

Clinicians are to administer emerging assessment measures at the initial interview and to monitor treatment progress, thus serving to promote the use of initial symptomatic status and reported outcome information (APA, 2013). The *DSM-5* cross-cutting symptom measures support comprehensive assessment by drawing attention to clinical symptoms that manifest across diagnoses. Cross-cutting symptom measures have two levels. Level 1 measures offer a brief screening of 13 domains for adults (i.e., depression, anger, mania, anxiety, somatic symptoms, suicidal ideation, psychosis, sleep problems, memory, repetitive thoughts and behaviors, dissociation, personality functioning, and substance use) and 12 domains for children and adolescents (i.e., depression, anger, irritability, mania, anxiety, somatic symptoms, inattention, suicidal ideation/attempt, psychosis, sleep disturbance, repetitive thoughts and behaviors, and substance use). Level 2 measures provide a more in-depth assessment of elevated Level 1 domains to facilitate differential diagnosis and determine severity of symptom manifestation. The *DSM-5* disorder-specific severity measures correspond closely to the criteria that constitute the disorder definition and are intended to illuminate additional areas of inquiry that may guide treatment and prognosis (APA, 2013; Jones, 2012). Counselors can access these no-cost assessment measures at http://psychiatry.org/practice/dsm/dsm5/online-assessment-measures. The *DSM-5* provides counselors with further information on the background and reasoning for use of these emerging measures in clinical practice (see pp. 733–748).

Autism Spectrum Disorder

The New Landscape

From as early as 1993, authors and researchers have referred to the various pervasive developmental disorders as *autism spectrum disorder* (Rutter & Schopler, 1992; Shuster, 2012; Tanguay, Robertson, & Derrick, 1998). They have also called for use of a dimensional rather than a categorical classification as used in *DSM-IV* and *DSM-IV-TR* (Kamp-Becker et al., 2010). Unlike the dichotomous approach of the *DSM-IV-TR* categorical model, the dimensional approach uses three or more rating scales to measure severity, intensity, frequency, duration or other characteristics of given diagnoses (Jones, 2012). Consensus in the research community for a spectrum classification is clearly demonstrated in that 95% of publications in the past 5 years have used the term "autism spectrum disorder." Hence, the *DSM-5* uses the term *spectrum* and further informs counselors that "autism spectrum disorder encompasses disorders previously referred to as early infantile autism, childhood autism, Kanner's autism, high-functioning autism, atypical autism, pervasive developmental disorder not otherwise specified, childhood disintegrative disorder, and Asperger's disorder" (APA, 2013, p. 53). Consolidating use of these dichotomous autism-based titles into a spectrum designation helps to avoid diagnostic confusion and to minimize fragmented treatment planning.

Based on factor structure models, the *DSM-5* presents a major reconceptualization and reorganization of the *DSM-IV-TR* autistic disorder symptomatology (Guthrie, Swineford, Wetherby, & Lord, 2013). This new spectrum, or dimensional classification, helps counselors to properly assess deficits in social-emotional reciprocity (i.e., the inability to engage with others and share thoughts and feelings); nonverbal communicative behaviors used for social interaction (i.e., absent, reduced or atypical use of eye contact [relative to cultural norms], gestures, facial expressions, body orientation or speech intonation); ability to develop, maintain and understand relationships (i.e., absent, reduced or atypical social interest, manifested by rejection of others, passivity or inappropriate approaches that seem aggressive or disruptive); and marked presentations

of restricted, repetitive patterns of behavior, interests or activities. This reconceptualization of autism in the *DSM-5* provides counselors with a denser diagnostic cluster to reduce excessive application of the *DSM-IV-TR pervasive developmental disorder not otherwise specified* classification that resulted in overdiagnosis and concerning prevalence rates (Maenner et al., 2014).

The *DSM-5* further recognizes autism due to Rett syndrome, Fragile X syndrome, Down syndrome, epilepsy, valproate, fetal alcohol syndrome or very low birth weight through use of the specifier *associated with a known medical or genetic condition or environmental factor*. Counselors also may use the specifiers *with or without accompanying intellectual impairment* and *with or without accompanying language impairment*. Examples of descriptive specifier usage include *with accompanying language impairment—no intelligible speech* or *with accompanying language impairment—phrase speech*. If catatonia is present, counselors record that separately as *catatonia associated with autism spectrum disorder*. Severity, or intensity of symptoms, for autism spectrum disorder are now communicated on three levels: *Level 1 mild requiring support*, *level 2 moderate requiring substantial support*, and *level 3 severe requiring very substantial support* (APA, 2013).

The level of interference in functioning and support required is communicated by using the *DSM-5* Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders scale (APA, 2013, p. 52). Examples of *mild* rating in the social communication psychopathological domain may include the following: without supports in place, deficits in social communication cause noticeable impairments; has difficulty initiating social interactions and demonstrates clear examples of atypical or unsuccessful responses to social overtures of others; and may appear to have decreased interest in social interactions. Examples of *mild* rating in the restricted interests and repetitive behaviors psychopathological domain may include rituals and repetitive behaviors (RRBs) that cause significant interference with functioning in one or more contexts, or resists attempts by others to interrupt RRBs or to be redirected from fixated interest (APA, 2013).

Examples of *moderate* rating in the social communication psychopathological domain may include marked deficits in verbal and nonverbal social communication skills, social impairments apparent even with supports in place, limited initiation of social interactions, and reduced or abnormal response to social overtures from others. Examples of *moderate* rating in the restricted interests and repetitive behaviors psychopathological domain may include RRBs and/or preoccupations and/or fixated interests that appear frequently enough to be obvious to the casual observer and inhibit functioning in a variety of contexts. Frustration or distress is apparent when RRBs are interrupted; it is difficult to redirect attention from fixated interest (APA, 2013).

Examples of *severe* rating in the social communication psychopathological domain may include severe deficits in verbal and nonverbal social communication skills that cause significant impairments in functioning, very limited initiation of social interactions, and minimal response to social advances from others. Examples of *severe* rating in the restricted interests and repetitive behaviors psychopathological domain may include preoccupations, fixed rituals and/or repetitive behaviors that significantly interfere with functioning in all domains; distinct distress when rituals or routines are interrupted; difficulty redirecting from fixated interest or returns to it quickly. Counselors are advised to review Table 2 Severity Levels for Autism Spectrum Disorder displayed in the *DSM-5* (APA, 2013, p. 52).

Clinical Scenario

Walter, a 22-year-old male, was referred to counseling by the State Office of Rehabilitation for career and vocational assistance, with a special focus on his mental health needs and confirming the presence of his previous diagnosis of Asperger's disorder given in 2004. Counselors working with adults presenting with autism spectrum symptoms will appreciate the *DSM-5*'s new adult textual narrative. Some of these additions help to understand adults like Walter, who:

- Must show persistent symptoms from early childhood across multiple contexts;
- Display difficulties processing and responding to complex social cues;
- Suffer from anxiety because of purposefully calculating what is socially intuitive for other adults;
- Express difficulty in coordinating nonverbal communication with speech;
- Struggle to comprehend what behavior is considered appropriate in one situation but not another; and
- Learn to suppress repetitive behavior in public.

Following assessment procedures outlined in the *DSM-5* to use "standardized behavioral diagnostic instruments with good psychometric properties, including caregiver interview, questionnaires and clinician observation measures" (APA, 2013, p. 55) and by Jones (2010), clinical assessment of Walter included the following:

- Biopsychosocial clinical interview of Walter with his mother as an additional informant
- Level 1 Cross-Cutting Symptom Measure (see APA, 2013, pp. 733–744 or www.psychiatry.org/dsm5)
- The Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders (see APA, 2013, p. 52 or www.psychiatry.org/dsm5)
- Historical evaluations (prior psychological testing results)
- Collateral reports from the referring vocational rehabilitation counselor
- Simon Baron-Cohen's Autism Spectrum Quotient (Baron-Cohen, Wheelwright, Skinner, Martin, & Clubley, 2001; Ketelaars et al., 2008)

Adhering to *DSM-5* dimensional rather than *DSM-IV-TR* multiaxial classification (Jones 2012), Walter was diagnosed using this format:

> 299.00 Autism spectrum disorder; requiring substantial support for social communication and social interaction (level 2 moderate); requiring support for restricted repetitive behaviors, interests and activities (level 1 mild); without accompanying intellectual impairment; without accompanying language impairment; without catatonia.

Notice the diagnostic precision offered by the *DSM-5* in comparison with Walter's non-descriptive diagnosis using the *DSM-IV-TR* formulation: Asperger's Disorder (APA, 2000). In contrast, the severity ratings for autism spectrum disorder are listed independently for social communication and restricted repetitive behaviors, rather than providing a global rating for both psychopathological domains (per the *DSM-5* they are listed from most severe to least severe). For Walter, his moderate severity rating of *requiring substantial support* for social communication means: "Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others" (APA, 2013, p. 52). His mild severity rating of *requiring support* for restricted repetitive behaviors (RRBs) means: "Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence" (APA, 2013, p. 52). The diagnostic formulation offered to counselors in the *DSM-5* provides a richer contextual description of the client to support more personalized treatment planning. This attention to dimensional ratings and individualized treatment strategies is also captured in the newly conceptualized schizophrenia spectrum disorders.

Schizophrenia Spectrum and Other Psychotic Disorders

The New Landscape

Counseling clients presenting with psychotic and schizophrenia spectrum disorders is challenging and diagnostically complex. To assist with these difficulties, the *DSM-5* presents a new conceptualization to

facilitate clinical utility and to streamline diagnostic formulations (Bruijnzeel & Tandon, 2011). Similar to autism, schizophrenia has been referenced as a *spectrum disorder* since 1995 (Kendler, Neale, & Walsh, 1995) and the *DSM-5* marks the official recognition of this spectrum conceptualization by embedding the word in the diagnostic title. Essential to competent practice in this area is reading the section on key features that define the psychotic disorders on pages 87–88 of the *DSM-5* (APA, 2013; e.g., delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior, and negative symptoms). Further critical reading is the new Clinician-Rated Assessment of Symptoms and Related Clinical Phenomena in Psychosis on the *DSM-5* pages 89–90 (APA, 2013). These pages describe the heterogeneity of psychotic disorders and the dimensional framework for the assessment of primary symptom severity within the psychotic disorders. This spectrum conceptualization differs from the *DSM-IV-TR* categorical and mutually exclusive diagnostic system that assumed "mental disorders are discrete entities, with relatively homogeneous populations that display similar symptoms and attributes of a disorder" (Jones, 2012, p. 481).

The new Clinician-Rated Dimensions of Psychosis Symptom Severity (CRDPSS) is used to understand the personal experience of the client, to promote individualized treatment planning, and to facilitate prognostic decision making (Flanagan et al., 2012; Heckers et al. 2013). Counselors can obtain the CRDPSS in the *DSM-5* pages 742–744 (APA, 2013) or www.psychiatry.org/dsm5. The CRDPSS is an eight-item measure used to assess the severity of mental health symptoms that are important across psychotic disorders. These symptoms include delusions, hallucinations, disorganized speech, abnormal psychomotor behavior, negative symptoms (i.e., restricted emotional expression or avolition), impaired cognition, depression and mania. Psychosis symptoms are rated on a five-point scale: not present, equivocal (severity or duration not sufficient to be considered psychosis), mild (little pressure to act, not very bothered by symptoms), moderate (some pressure to respond or somewhat bothered by symptoms) and severe (severe pressure to respond to voices or very bothered by voices).

According to the *DSM-5*, proper use of the CRDPSS may include clinical neuropsychological assessment (especially of client cognitive functioning) to help guide diagnosis and treatment. Counselor "assessment of [client] cognition, depression, and mania symptom domains is vital for making critically important distinctions between the various schizophrenia spectrum and other psychotic disorders" (APA, 2013, p. 98). Depending on the stability of client symptoms and treatment status, the CRDPSS may be completed at regular intervals as clinically indicated to track changes in client symptom severity over time. Consistently high scores on a specific domain may indicate significant and problematic areas for the client that may warrant further assessment (mental status examination), treatment (counseling and pharmacological), and follow-up (case management).

In the *DSM-5*, delusional disorder is retained as listed in *DSM-IV-TR*, including its classic subtypes of erotomanic, grandiose, jealous, persecutory and somatic. Some textual updates occur in the *DSM-5* for brief psychotic disorder that place emphasis on disorganized or catatonic behavior. Schizophreniform disorder in the *DSM-5* parallels the description in the *DSM-IV-TR*. Diagnostic precision for schizophrenia in the *DSM-5* is communicated with new course specifiers that can "be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria" (APA, 2013, p. 99). These new course specifiers communicate a time period in which the symptom criteria are fulfilled (acute), a period of time during which improvement after a previous episode is maintained and in which the defining criteria of the disorder are only somewhat fulfilled (partial remission), or a period of time after a prior episode during which no disorder-specific symptoms are present (full remission). Counselors also can communicate these specifiers based on first episode, multiple episodes, continuous episodes or unspecified. Use of these specifiers assists counselors in determining the intensity, frequency and duration of clinical intervention services that are more person-centered.

To align with a dimensional, or spectrum paradigm, the categorical *DSM-IV-TR* schizophrenia subtypes (i.e., paranoid type, disorganized type, catatonic type, undifferentiated type and residual type) are not used in the *DSM-5* because they are included in the previously described CRDPSS. Research also does not support the use of the subtypes and does not indicate any qualitative differences between the subtypes that impact treatment planning or symptom presentation (Tandon et. al., 2013). Catatonia, a syndrome of disturbed motor, mood and systemic signs, becomes a specifier in the *DSM-5,* applicable for neurodevelopmental, depressive, bipolar and all psychotic disorders (APA, 2013). Unlike the *DSM-IV-TR*, the *DSM-5* does not contain the following exception clause to diagnose schizophrenia: "Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the persons' behavior or thoughts, or two or more voices conversing with each other" (APA, 2000, p. 312). Removal of this language restricts classification to avoid excessive classification in nonclinical profiles, thus promoting ethical practice (ACA, 2014).

Although the *DSM-5* acknowledges that "there is growing evidence that schizoaffective disorder is not a distinct nosological category" (APA, 2013, pp. 89–90; see also Malaspina et al., 2013), this disorder is retained, with some textual refinements to more stringently define the clinical syndrome. These changes include the following: criterion B: "lifetime duration of the illness" (APA, 2013, p. 105); and criterion C: major mood episode must be "present for the majority of the total duration for the active and residual portion of the illness" (APA, 2013, p. 105) instead of the *DSM-IV-TR*'s focus on substantial portion for the active and residual portion of the illness.

Clinical Scenario

Ryan, a 22-year-old Caucasian male, presented with an extensive history of auditory hallucinations and erotomanic and paranoid delusions. In the spirit of the *DSM-5*, he was administered the CRDPSS six times, beginning with the onset of counseling and then at various counseling sessions during his treatment. Use of the CRDPSS promotes clinical utility. For example, Ryan is able to identity trends and patterns related to life stressors and symptom elevations and reductions. This level of clinical assessment provides a framework for targeted treatment planning and clinical intervention. Ryan also feels empowered over his mental illness and obtains a more positive perspective regarding his self-efficacy with coping skills to manage his psychotic symptoms. Most importantly, the CRDPSS encourages measurement-based care in the burgeoning era of practice-based evidence requirements (Tandon et al., 2013). Adhering to the *DSM-5* dimensional classification, I diagnosed Ryan using this format:

> 295.70 Schizoaffective disorder, bipolar type, severe hallucinations, moderate delusions (erotomanic and persecutory), moderate abnormal psychomotor behavior, moderate negative symptoms, equivocal disorganized speech, continuous episode, currently in partial remission, without catatonia.

Compare the *DSM-5* clinical formulation to the *DSM-IV-TR* diagnostic formulation:

> 295.70 Schizoaffective disorder, bipolar type.

The *DSM-5* diagnostic conceptualization offers a contextualized framework in "developing a comprehensive treatment plan that is informed by the individual's cultural and social context" (APA, 2013, p. 19) by rating primary symptoms of psychosis in order of severity so as to promote prognostic decision-making. This level of diagnostic specificity also is found in the *DSM-5* sleep-wake disorders.

Sleep-Wake Disorders

The New Landscape

Sleep-wake disorders in the *DSM-5* represent a radical revamping of diagnostic syndromes, clinical conceptualization and specifier annotations. This is because the "*DSM-IV* was prepared for use by mental health and general medical clinicians who are not experts in sleep medicine" (APA, 2013, p. 362). Grounded in the current International Classification of Sleep Disorders, 2nd edition (ICSD-2), the *DSM-5* sleep-wake disorders work group used this classification system as a benchmark for diagnostic revision. When counselors read each sleep-wake disorder in the *DSM-5*, they will discover that a note about relationship to the *ICSD* is presented. Because of the new sleep-wake disorder conceptualization and the dimensional (instead of categorical) formulation of mental disorders in the *DSM-5*, counselors are to use the emerging measures for sleep-wake disorders for children and adults located at www.psychiatry.org/dsm5.

As counselors read the sleep-wake disorders chapter in the *DSM-5*, they will notice an increased emphasis on a multidimensional approach to assessment that includes medical examination, such as the use of polysomnography, quantitative electroencephalographic analysis and testing for hypocretin (orexin) deficiency (APA, 2013). They will also notice a greater emphasis on the dynamic relationship between sleep-wake disorders and certain mental or medical conditions, and that pediatric and developmental criteria and the general text are integrated based on existing neurobiological and genetic evidence and biological validators (Kaplan, 2013). The *DSM-5* sleep-wake disorders textual descriptors use the terminology "coexisting with" or "comorbidity" instead of the *DSM-IV-TR* "related to" or "due to." Sleep-wake disorders in the *DSM-5* further provide diagnostic precision by offering use of course specifiers (i.e., episodic, persistent, recurrent, acute, subacute), descriptive specifiers (i.e., with mental disorder, with medical condition, with another sleep disorder), and severity specifiers (i.e., mild, moderate, severe).

The insomnia-based sleep-wake disorders focus on problems with initiating or maintaining quality sleep. Some of these disorders preclude assessment by a counselor, as they require examination by a sleep medicine expert. The *DSM-IV-TR* primary insomnia and insomnia related to another mental disorder are merged in the *DSM-5* to become insomnia disorder. The *DSM-IV-TR* primary hypersomnia and hypersomnia related to another mental disorder are merged to become the *DSM-5* hypersomnolence disorder. Narcolepsy is retained in the *DSM-5* with substantial symptom description changes, five new specifiers and requirements for sleep medicine examination to confirm a diagnosis. Narcolepsy now requires either the presence of cataplexy (sudden loss of muscle tone), hypocretin deficiency as measured using cerebrospinal fluid, or REM sleep latency deficiency as measured using polysomnography (APA, 2013). Breathing-related sleep disorders in the *DSM-5* include obstructive sleep apnea hypopnea, central sleep apnea (new for the manual) and sleep-related hypoventilation (new for the manual). Circadian rhythm sleep-wake disorders in the *DSM-5* no longer recognize jet lag, resulting in five types (i.e., delayed sleep phase, advanced sleep phase, irregular sleep-wake, non-24-hour sleep-wake and shift work) for counselors to select when diagnosing this syndrome. Parasomnias, defined as abnormal behavior or physiological events during sleep, also are reconceptualized in the *DSM-5*. The *DSM-IV-TR* sleepwalking disorder and sleep terror disorder are merged to become the *DSM-5* non–rapid eye movement sleep arousal disorder, with sleepwalking type, sleep-related eating, sleep-related sexual behavior, and sleep terror type specifiers (APA, 2013). Nightmare disorder is retained with no substantial changes from the *DSM-IV-TR*. The *DSM-IV-TR* parasomnia not otherwise specified is renamed in the *DSM-5* to rapid eye movement sleep behavior disorder for disruptive dream enacting behaviors, and *DSM-IV-TR* dyssomnia not otherwise specified is renamed in the *DSM-5* to restless legs syndrome.

Clinical Scenario

Jasmine, a 36-year-old Caucasian female, is married and has four children. She reported a history of major depression (with two to three episodes of intense suicidal ideation) and generalized anxiety disorder. Results from the World Health Organization's *Adult ADHD Self-Report Scales* (Kessler et al., 2004) indicated possible attention-deficit/hyperactivity disorder combined presentation. Results from the psychometric *Conners' Continuous Performance Test II* confirmed the presence of a mild to moderate ADHD combined presentation profile. Despite pharmacological (both prescription and over the counter) and psychological (sleep hygiene and behavioral-focused) interventions, Jasmine continued to report daytime sleepiness, fatigue and unrefreshing sleep throughout the week, lasting for many months. This produced functional impairment with employment obligations and interpersonal relationships.

In the spirit of the *DSM-5* and in collaboration with her general practitioner, Jasmine was referred to a local sleep medicine clinic to receive formal sleep-wake disorder testing (polysomnography). This was done to confirm the presence of an independent sleep-wake disorder not better accounted for by her depression and anxiety disorders. The resulting sleep-wake study report included the following excerpts:

> This is 36-year-old female patient with a past medical history that is remarkable for gastric reflux, allergies and asthma. Patient is overweight with a BMI (body mass index) of 26.31. There is a longstanding history of: frequent awakenings, use of sleeping pills, frequent difficulty waking up, nonrestorative sleep, excessive daytime sleepiness, nasal congestion, frequent loud snoring, palpitations, night sweats and waking up with muscle paralysis. Patient complains of excessive daytime sleepiness with an Epworth Sleepiness score that is abnormal at 14 out of 24. Total sleep time is adequate at 8 hours per night. Patient denies smoking and drinking alcohol. Current medications include: Pantoprazole, Simvastatin, Amitriptyline, Loratadine and Fluticasone. As such, an overnight sleep study was ordered for evaluation of an underlying sleep-related breathing disorder.
>
> Interpretation:
> - Obstructive apneas (suspension of external breathing) of 17.1/hour associated with oxygen desaturation to as low as 72%. This is consistent with the diagnosis of moderate Obstructive Sleep Apnea.
> - Sleep-related hypoventilation/hypoxemia due to sleep apnea is present.
> - Severe initial insomnia.
>
> Recommendations:
> - Continuous positive airway pressure (CPAP) therapy should be offered to this patient given the risk of stroke and the significant daytime sleepiness. As such, a second overnight sleep study for CPAP titration is strongly recommended. If daytime sleepiness persists despite adequate CPAP therapy, then further evaluation for hypersomnolence should be considered.

Recall that hypersomnolence, excessive sleepiness, is a new disorder for the *DSM-5*. Addition of this diagnosis conforms to the sleep medicine expert's recommendation for potential comorbid existence.

Adhering to the *DSM-5* dimensional rather than the *DSM-IV-TR* multiaxial classification (Jones, 2012), Jasmine received the following diagnostic formulation:

- 327.23 Moderate obstructive sleep apnea hypopnea (see APA, 2013, pp. 378–383);
- V61.10 Relationship distress with spouse (see APA, 2013, p. 716);

- 296.32 Moderate major depressive disorder, recurrent (the Level 2 — Depression—Adult [PROMIS Emotional Distress—Depression—Short Form] and the Severity Measure for Depression—Adult [Patient Health Questionnaire–9] were administered to determine severity rating (see also Jones, 2012; APA, 2014);
- 327.24 Mild idiopathic sleep-related hypoventilation (see APA, 2013, pp. 387–390);
- 314.01 Mild attention-deficit/hyperactivity disorder, combined presentation, in partial remission (see APA, 2013, pp. 60–61 for discussion on new severity and remission specifier options); and
- 300.02 Mild generalized anxiety disorder (the Severity Measure for Generalized Anxiety Disorder—Adult [APA, 2014] was administered to determine severity rating).

Counselors are reminded that depression, anxiety and cognitive changes often accompany sleep-wake disorders and must be addressed in treatment planning and management (APA, 2013). To assist with targeted treatment interventions for sleep-wake disorders, counselors are encouraged to use Milner and Belicki's (2010) sleep hygiene recommendations.

Neurocognitive Disorders

The *DSM-IV-TR* chapter "Dementia, Delirium, Amnestic, and Other Cognitive Disorders" is renamed to "Neurocognitive Disorders" (NCDs) in the *DSM-5*. Cognitive impairments occur in most mental disorders, including schizophrenia, bipolar disorder, depression, attention-deficit/hyperactivity disorder and autism (APA, 2013). However, the *DSM-5* NCDs work group focused on those disorders for which the cognitive deficit is the primary one and is attributable to known physical or metabolic brain disease—hence the designation *neurocognitive* (Campbell, 2013).

To delineate between normative aging declines and lifelong patterns, the *DSM-5* requires neuropsychological testing as part of the clinical evaluation process (except for delirium). Compared to the *DSM-IV-TR*, the NCDs in the *DSM-5* represent a significant reorganization and reconceptualization (Ganguli, 2011) reflected in two new diagnostic categories: major and mild NCDs (Geda & Nedelska, 2012). Major NCD is characterized by significant cognitive decline, interference with activities of daily living, and symptom manifestation two or more standard deviations from the mean on neurocognitive domains (see Table 1, APA, 2013, pp. 593–595). Specifiers for the major NCD designation include *mild* (difficulties with instrumental activities of daily living, such as housework or managing money), *moderate* (difficulties with basic activities of daily living, such as feeding and dressing), and *severe* (fully dependent).

In contrast to major NCD, mild NCD is characterized in the *DSM-5* as modest cognitive decline, intact activities of daily living, and symptom manifestation one standard deviation from the mean on neurocognitive domains. Mild NCD is a former diagnostic consideration from the *DSM-IV-TR* (2000) Appendix B: Criteria Sets and Axes Provided for Further Study (p. 764). Mild NCD is considered an *up-streaming* diagnostic conceptualization to assist with early diagnostic detection because the neuropathology underlying mild NCD emerges well before the onset of clinical symptoms (APA, 2013).

The *DSM-5* offers two new NCD designations: probable and possible. *Probable* is added to the diagnostic title if there is evidence of a causative disease genetic mutation from either genetic testing, evidence of family history, evidence from laboratory blood testing, or evidence from neuroimaging. *Possible* is used if there is no evidence resulting from the previously mentioned probable objective factors (APA, 2013). Counselors also may use the retained *DSM-IV-TR* descriptive specifier, *without* or *with behavioral disturbance* to indicate the presence of psychotic symptoms, mood disturbance, agitation, apathy or other behavioral symptoms.

The *DSM-5* contains 10 etiological specifiers (formally referred to as subtypes in the *DSM-IV-TR*). The *DSM-5* changed the title of the *DSM-IV-TR* Pick's disease to frontotemporal lobar degeneration and changed the *DSM-IV-TR*'s Creutzfeldt–Jakob disease to Prion disease so as to more objectively communicate the active pathophysiological mechanisms responsible for the neuronal degeneration and resulting cognitive disturbances (APA, 2013). The *DSM-5* added Lewy body disease and multiple etiologies as etiological specifiers and merged the *DSM-IV-TR* dementia due to head trauma and postconcussional disorder (found in Appendix B: Criteria Sets and Axes Provided for Further Study) to become traumatic brain injury (TBI). Counselors will appreciate the table listed on page 626 (APA, 2013) that presents severity ratings for TBI, and will find that Jones, Young, and Leppma's (2010) article complements the *DSM-5* conceptualization of TBI and offers additional assessment and diagnostic assistance.

Clinical Scenario

Jaxson, a male client in his mid-40s who suffered three TBIs, each resulting from independent automobile accidents, presented for counseling. He presented with post-concussion syndromes reflected in physical symptoms (headaches, dizziness, fatigue, noise/light intolerance, insomnia, nausea, physical weakness), cognitive symptoms (memory complaints, poor concentration), and emotional symptoms (depression, anxiety, irritability, increased aggression, mood lability). Textual additions to the *DSM-5* further explained the causal relationship between TBIs and major depressive episodes, facilitating a more accurate clinical formulation. The most salient *DSM-5* (APA, 2013) diagnostic guidelines included the following:

- With moderate and severe TBI, in addition to persistence of neurocognitive deficits, there may be associated neurophysiological, emotional, and behavioral complications. These may include . . . depression, sleep disturbance, fatigue, apathy, inability to resume occupational and social functioning at pre-injury level, and deterioration in interpersonal relationships.
- Moderate and severe TBI have been associated with increased risk of depression. (p. 626)
- Individuals with TBI histories report more depressive symptoms, and these can amplify cognitive complaints and worsen functional outcome. (p. 627)
- There are clear associations, as well as some neuroanatomical correlates, of depression with . . . traumatic brain injury. (p. 181)

Using the *DSM-5*'s Severity Ratings for TBI, three previously administered clinical neuropsychological tests and the *DSM-5*'s Table 1 Neurocognitive Domains, Jaxson received the following dimensional diagnostic formulation per the *DSM-5* (APA, 2013):

- 293.83 Moderate-severe depressive disorder due to TBI, with major depressive-like episode (p. 181; coding rules require that a mental disorder due to another medical condition be listed first; pp. 22–23);
- Moderate-mild disability (87 per self-administered World Health Organization Disability Assessment Schedule [WHODAS] 2.0; pp. 745–748);
- 331.83 Probable mild neurocognitive disorder (NCD) due to TBI (pp. 624–627);
- V62.29 Other problem related to employment (recent change of job, underemployment and psychosocial stressors related to work due to TBI; p. 723); and
- V61.29 Relationship distress with spouse (due to TBI; p. 716).

This approach to clinical case formulation also is demonstrated in the assessment and diagnosis of post-traumatic stress disorder and excoriation (skin-picking) disorder.

Comorbid Diagnostic Formulation

Comorbidity refers to the presence of multiple diagnoses or pathologies within the same individual (Jones, 2012). This final section presents a discussion on the *DSM-5*'s new obsessive-compulsive and related disorder, excoriation (skin-picking) disorder and the revised conceptualization of post-traumatic stress disorder.

Excoriation (Skin-Picking) Disorder

Excoriation, also referred to as dermatillomania (Grant et al., 2012), is characterized by the repetitive and compulsive picking of skin, leading to tissue damage, and is a new diagnosis to the *DSM-5*. This addition reflects the growing prevalence of this psychiatric condition (Grant et. al., 2012). Excoriation is characterized by compulsive picking, rubbing, squeezing, lancing or biting of the skin. Not included in this disorder are individual behaviors that involve nail biting, lip biting or cheek biting. If individuals manifest these conditions they are coded as *other specified obsessive-compulsive related disorder* (APA, 2013, p. 263). Cutting, or nonsuicidal self-injury, is not a codable mental disorder in the *DSM-5* (see APA, 2013, pp. 803–806) and is not conceptualized in the symptomology of excoriation. Counselors are encouraged to consider cutting behavior in their clients as manifestations of symptoms related to depressive disorders, bipolar disorders, anxiety disorders, trauma disorders—and most particularly dissociative identity disorder and borderline personality disorder, in which self-injurious behavior is frequent. Individuals engaged in excoriation may target their face, arms, hand, skin irregularities, pimples, calluses or scabs. They may use objects such as tweezers, pins, scissors and fingernails and be triggered by anxiety, boredom, distress or tension (Grant et al., 2012). Some individuals with excoriation display rituals (e.g., biting off, chewing and swallowing skin), permanent skin damage, scarring, lesions, infection or disfigurement. Individuals with excoriation spend several hours per day for months and years picking at their skin, thinking about picking, and resisting urges to pick. Because the skin-picking is so frequent, pain is not routinely reported. Marked functional impairment from excoriation may include work interference, missed school, difficulty managing school tasks and studying, and avoidance of social or entertainment events. Excoriation cannot be due to physiological effects of a substance (e.g., methamphetamine or cocaine), to another medical condition (e.g., scabies), or better explained by symptoms of another disorder (APA, 2013).

Post-Traumatic Stress Disorder

Some important modifications to post-traumatic stress disorder occur in the *DSM-5*. First, the *DSM-IV-TR* language has shifted from "threat to the physical integrity of self or others" (APA, 2000, p. 467) to "sexual violence" (APA, 2013, p. 271). Second, the *DSM-5* removed the *DSM-IV-TR* criterion A2 "subjective fear-based distress" because not all traumatized individuals experience fear, terror or horror when exposed to a trauma stressor. Some traumatized individuals may become anhedonic, dysphoric, aggressive or phobic; experience arousal and reactive-externalizing behaviors; or experience dissociation. Third, a new trauma exposure source is added to the traditional *DSM-IV-TR* trauma sources (i.e., directly experiencing, witnessing, and learning that a traumatic event occurred to a close family member or friend): "experiencing repeated or extreme exposure to aversive details of the traumatic event(s)" (APA, 2013, p. 271). An important note regarding this new exposure source in the *DSM-5* indicates that "criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless exposure is work related" (APA, 2013, p. 271). Examples of work-related electronic media exposure may include an individual who edits graphic news video or pictures, an individual who performs frequent digital-based forensic science investigations of graphic crime scenes, or an individual who views military-oriented electronic images displaying graphic human remains captured from unmanned aerial vehicles. Fourth, the *DSM-5* requires that an individual manifest at least one symptom from each of the following pathological clusters:

- Intrusion symptoms;
- Persistent avoidance of stimuli;
- Negative alterations in cognitions and mood (new to the *DSM-5*); and
- Marked alterations in arousal and reactivity.

Fifth, the *DSM-IV-TR* specifier "delayed onset" is renamed to "delayed expression" in the *DSM-5* so as to communicate whether the full diagnostic criteria are not met until at least 6 months after the trauma-causing event (APA, 2013, p. 272). Sixth, "with dissociative symptoms" (Dalenberg & Carlson, 2012) is a new descriptive specifier that can include either *depersonalization* (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly) or *derealization* (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted; APA, 2013). Seventh, separate diagnostic criterion exist for children ages 6 years and younger. Counselors are encouraged to read van den Heuvel and Seedat (2013) for a detailed review of screening measures and diagnostic instruments for post-traumatic stress disorder in preschool populations.

Clinical Scenario

Mary, a female in her mid-50s, presented with an extensive history of sexual trauma resulting in post-traumatic stress disorder and excoriation. To verify the presence and severity of her trauma and excoriation, Mary was administered the *DSM-5* Level 1 cross-cutting symptom measure. Elevated responses (i.e., *feeling nervous, anxious, frightened, worried, or on edge* and *feeling driven to perform certain behaviors or mental acts over and over again*) triggered administration of the *DSM-5* Level 2 cross-cutting symptom measures (i.e., the Repetitive Thoughts and Behaviors Scale, the National Stressful Events Survey PTSD Short Scale, and the Modified Brief Dissociative Experiences Scale). Adhering to the *DSM-5* dimensional classification, Mary's diagnostic formulation was conceptualized in the following format:

- 309.81 Moderate post-traumatic stress disorder, with mild depersonalization
- 698.4 Excoriation (skin-picking) disorder.

This diagnostic formulation contains a layered intensity description as both the disorder and the descriptive specifier have a severity rating; hence promoting clinical utility by informing Mary's treatment plan and assisting with prognostic and outcome factors (APA, 2013). For example, this level of diagnostic precision targeted Mary's cognitive, affective and behavioral post-traumatic and depersonalization symptoms individually, rather than globally.

Conclusion

The *DSM-5* represents 12 years of culminating work among hundreds of medical and mental health professionals. The manual was revised in a manner so as to stimulate new clinical perspectives, to promote a new generation of research into the biological markers of mental health disorders and to facilitate more reliable diagnoses of the disorders (APA, 2013). This article presented clinical scenarios from actual clients the author worked with in an outpatient counseling private practice. The intent is that counselors feel more comfortable and confident in their use of the *DSM-5* to develop a counseling professional identity that stimulates client growth and development (Erikson & Kress, 2006; King, 2012).

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References

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Baron-Cohen, S., Wheelwright, S., Skinner, R., Martin, J., & Clubley, E. (2001). The autism-spectrum quotient (AQ): Evidence from Asperger Syndrome/high-functioning autism, males and females, scientists and mathematicians. *Journal of Autism and Developmental Disorders*, *31*, 5–17. doi:10.1023/A:1005653411471

Beglinger, L. J., & Smith, T. H. (2001). A review of subtyping in autism and proposed dimensional classification model. *Journal of Autism and Developmental Disorders*, *31*, 411–422. doi:10.1023/A:1010616719877

Bruijnzeel, D., & Tandon, R. (2011). The concept of schizophrenia: From the 1850s to the *DSM-5*. *Psychiatric Annals*, *41*, 289–295. doi:10.3928/00485713-20110425-08

Campbell, J. J. (2013). What neuropsychiatrists would like to see in DSM-5. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *25*, 6–11. doi:10.1176/appi.neuropsych.11040097

Dalenberg, C., & Carlson, E. B. (2012). Dissociation in posttraumatic stress disorder part II: How theoretical models fit the empirical evidence and recommendations for modifying the diagnostic criteria for PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy*, *4*, 551–559. doi: 10.1037/a0027900

Eriksen, K., & Kress, V. E. (2006). The DSM and professional counseling identity: Bridging the gap. *Journal of Mental Health Counseling*, *28*, 202–217.

Flanagan, E. H., Solomon, L. A., Johnson, A., Ridgway, P., Strauss, J. S., & Davidson, L. (2012). Considering *DSM-5*: The personal experience of schizophrenia in relation to the *DSM-IV-TR* criteria. *Psychiatry*, *75*, 375–386. doi:101521psyc2012754375

Ganguli, M., Blacker, D., Blazer, D. G., Grant, I., Jeste, D. V., Paulsen, J. S., . . . Sachdey, P. S. (2011). Classification of neurocognitive disorders in *DSM-5*: A work in progress. *The American Journal of Geriatric Psychiatry*, *19*, 205–210. doi:10.1097/JGP.0b013e3182051ab4

Geda, Y. E., & Nedelska, Z. (2012). Mild cognitive impairment: A subset of minor neurocognitive disorder? *The American Journal of Geriatric Psychiatry*, *20*, 821–826. doi:10.1097/JGP.0b013e31826abc00

Grant, J. E., Odlaug, B. L., Chamberlain, S. R., Keuthen, N. J., Lochner, C., & Stein, D. J. (2012). Skin picking disorder. *The American Journal of Psychiatry*, *169*, 1143–1149.

Guthrie, W., Swineford, L. B., Wetherby, A. M., & Lord, C. (2013). Comparison of DSM-IV and DSM-5 factor structure models for toddlers with autism spectrum disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*, 797–805. doi:10.1016/j.jaac.2013.05.004

Heckers, S., Barch, D. M., Bustillo, J., Gaebel, W., Gur, R., Malaspina, D., . . . Carpenter, W. (2013). Structure of the psychotic disorders classification in DSM-5. *Schizophrenia Research*, *150*, 11–14. doi:10.1016/j.schres.2013.04.039

Jones, K. D. (2010). The unstructured clinical interview. *Journal of Counseling & Development*, *88*, 220–226. doi:10.1002/j.1556-6678.2010.tb00013.x

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development*, *90*, 481–487.

Jones, K. D., Young, T., & Leppma, M. (2010). Mild traumatic brain injury and posttraumatic stress disorder in returning

Iraq and Afghanistan war veterans: Implications for assessment and diagnosis. *Journal of Counseling & Development*, *88*, 372–376. doi:10.1002/j.1556-6678.2010.tb00036.x

Kamp-Becker, I., Smidt, J., Ghahreman, M., Heinzel-Gutenbrunner, M., Becker, K., & Remschmidt, H. (2010). Categorical and dimensional structure of autism spectrum disorders: The nosologic validity of Asperger syndrome. *Journal of Autism and Developmental Disorders*, *40*, 921–929. doi:10.1007/s10803-010-0939-5

Kaplan, A. (2013, August 26). Catching up on sleep: From comorbidity to pharmacotherapy. *Psychiatric Times*, *30*, 16G. Retrieved from http://www.psychiatrictimes.com/printpdf/177755

Kendler, K. S., Neale, M. C., & Walsh, D. (1995). Evaluating the spectrum concept of schizophrenia in the Roscommon Family Study. *The American Journal of Psychiatry*, *152*, 749–754.

Kessler, R. C., Adler, L., Ames, M., Demler, O., Faraone, S., Hirpis, E., . . . Walters, E. E. (2004). The World Health Organization adult ADHD self-report scale (ASRS): A short screening scale for use in the general population. *Psychological Medicine*, *35*, 245–256. doi:10.1017/S0033291704002892

Ketelaars, C., Horwitz, E., Sytema, S., Bos, J., Wiersma, D., Minderaa, R., & Hartman, C. A. (2008). Brief report: Adults with mild autism spectrum disorders (ASD): Scores on the autism spectrum quotient (AQ) and comorbid psychopathology. *Journal of Autism and Developmental Disorders*, *38*, 176–180. doi:10.1007/s10803-007-0358-4

King, J. H. (2012). *How ethical codes define counselor professional identity* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Order No. 3505737)

Maenner, M. J., Rice, C. E., Arneson, C. L., Cunniff, C., Schieve, L. A., Carpenter, L. A., . . . Durkin, M. S. (2014). Potential impact of DSM-5 criteria on autism spectrum disorder prevalence estimates. *JAMA Psychiatry*, *71*, 292–300. doi:10.1001/jamapsychiatry.2013.3893

Malaspina, D., Owen, M. J., Heckers, S., Tandon, R., Bustillo, J., Schultz, S., . . . Carpenter, W. (2013). Schizoaffective disorder in the DSM-5. *Schizophrenia Research*, 150, 21–25. doi:10.1016/j.schres.2013.04.026

Milner, C. E., & Belicki, K. (2010). Assessment and treatment of insomnia in adults: A guide for clinicians. *Journal of Counseling & Development*, *88*, 236–244. doi:10.1002/j.1556-6678.2010.tb00015.x

Rutter, M., & Schopler, E. (1992). Classification of pervasive developmental disorders: Some concepts and practical considerations. *Journal of Autism and Developmental Disorders*, *22*, 459–482. doi:10.1007/BF01046322

Shuster, J. (2012). *Autism spectrum disorder symptoms: An examination of new and existing models* (Doctoral dissertation, York University, Toronto, Canada). Retrieved from http://www.proquest.com/products-services/dissertations/

Tandon, R., Gaebel, W., Barch, D. M., Bustillo, J., Gur, R. E., Heckers, S., . . . Carpenter, W. (2013). Definition and description of schizophrenia in the DSM-5. *Schizophrenia Research*, *150*, 3–10. doi:10.1016/j.schres.2013.05.028

Tanguay, P. E., Robertson, J., & Derrick, A. (1998). A dimensional classification of autism spectrum disorder by social communication domains. *Journal of the American Academy of Child & Adolescent Psychiatry*, *37*, 271–277. doi:10.97/00004583-199803000-00011

van den Heuvel, L. L., & Seedat, S. (2013). Screening and diagnostic considerations in childhood post-traumatic stress disorder. *Neuropsychiatry*, *3*, 497–511. doi:10.2217/npy.13.61

Evaluating Emerging Measures in the *DSM-5* for Counseling Practice

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The American Psychiatric Association introduced emerging measures to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) classification system. The authors present a primer on dimensional assessment and a review of the emerging measures endorsed by the American Psychiatric Association. The development of the emerging measures is discussed in light of the 1999 *Standards for Educational and Psychological Testing* and the *DSM-5* criteria, showing that the measures lack conformity to various evidences of validity and lack alignment with the *DSM-5* criteria. Hence, counselors should be cautious in the adoption of such measures because the measures may not augment comprehensively the categorical system of diagnosis currently endorsed by the American Psychiatric Association.

***Keywords*: diagnosis, dimensional assessment, *DSM-5*, measures, American Psychiatric Association**

Historically, counselors relied on the categorical system of diagnosis employed by the American Psychiatric Association (APA) and included in the variations of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). Jones (2012) highlighted the introduction of dimensional measures for diagnosis in the fifth edition of the *DSM* (*DSM-5*). Whereas a categorical approach to diagnosis classifies a diagnosis as either present or absent, a dimensional approach to diagnosis entails using measures to evaluate the extent to which symptoms exist (Jones, 2012). Hence, the dimensional approach provides a continuum to evaluate symptoms, whereas a categorical system does not. The APA (2013g) affirmed that the measures in the *DSM-5* are to be used in conjunction with other diagnostic materials and that they are designed to provide a dimensional approach to diagnosis, as opposed to a categorical approach. The purpose of this article is to review the dimensional measures in conjunction with diagnostic criteria and standards for psychological measures.

The dimensional approach to diagnosis does have certain advantages, such as the ability to address comorbid symptoms and an increased utility in research (Bjelland et al., 2009; Jones, 2012; Kraemer, Noda, & O'Hara, 2004). However, categorical approaches to diagnosis are more easily operationalized (Bjelland et al., 2009) and dimensional diagnoses can be converted easily to cut-points to provide a categorical system (Kraemer et al., 2004). Clinical utility is a primary concern with implementing dimensional classifications for diagnoses (Livesley, 2007). With respect to the medical model, physicians diagnose and treat an illness; hence, an illness is present (and therefore treated) or is not present. Dimensional diagnoses present a different paradigm in which a disorder exists on a continuum. If a disorder is only somewhat present, the justification for treatment often becomes ambiguous, and consequently, the processes of charting the course of the diagnosis and conducting

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research become ambiguous as well. However, given the propensity of researchers to utilize instruments that measure constructs on a continuum, dimensional classifications may offer a method of demonstrating variability within a diagnosis (Helzer, van den Brink, & Guth, 2006). Dimensional classifications may be more helpful in measuring symptoms related to personality disorders (Livesley, 2007), anxiety and depression (Bjelland et al., 2009), and substance use (Helzer et al., 2006), due to the employment of different treatment modalities based on symptom severity. For example, medication management may not be considered with mild depression even though it may be effective; however, it may become a stronger consideration with moderate or severe depression (Stewart, Deliyannides, Hellerstein, McGrath, & Stewart, 2012).

Livesley (2007) advocated for integrating categorical and dimensional classifications for diagnoses. However, Helzer et al. (2006) indicated that a dimensional diagnosis must be associated with the operational definition of the said diagnosis, which implies that dimensional assessments must address the appropriate content to obtain a valid measure of the intended classification (i.e., diagnosis). What follows is an overview of evidences of validity for measures and an evaluation of dimensional measures advocated by the APA (2013g).

Cross-Cutting Symptom Measures

The APA (2013g) provided a section in the *DSM-5* titled "Emerging Measures and Models" (p. 729) that contained "tools and techniques to enhance the clinical decision-making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study" (p. 731). At the forefront of this section the APA introduced *cross-cutting symptom measures* (CCSMs), which are utilized for consideration across diagnostic symptoms. The *DSM-5* only includes a few CCSMs, but the APA's website (2014) offers access to a comprehensive list of CCSMs. CCSMs include two levels; Level 1 is concise, including 1–4 items on each domain, while Level 2 is more comprehensive, including a measure for each domain. The Level 1 CCSMs are more general measures that include symptoms across domains consistent with common diagnostic categories (e.g., depression, anxiety; APA, 2013g) and assess a wider scope of time (i.e., two weeks). The Level 1 CCSMs are designed for adults (23 items across 13 domains) or children (25 items across 12 domains). Adults and children/adolescents between the ages of 11 and 17 may complete self-report versions. A parent/guardian version is available for children between the ages of 6 and 17.

The Level 2 CCSMs are utilized after finding threshold scores from Level 1 measures. Level 2 measures contain more detailed symptom investigation that can help with diagnosis and treatment, including assessment of a shorter time period (i.e., 7 days). Level 2 measures include such symptoms as depression, anger, mania, anxiety, somatic symptoms, sleep disturbance, repetitive thoughts and behaviors, substance abuse, inattention, and irritability. Certain measures address how often the individual has been bothered by a symptom within a time period of 7 days, and others ask the individual to pick a statement in a cluster that best represents the way he or she has been feeling within the past 7 days. Similar to the Level 1 measures, adults and children/adolescents between the ages of 11 and 17 may complete a self-report version; a parent/guardian version is available for children between the ages of 6 and 17. These measures are to be used at the early stages of treatment and throughout the treatment process.

When comparing the Level 2 measures advocated by the APA (2013g) to the emotional and behavioral symptoms included in the *DSM-5* diagnoses, many crucial criteria are absent, thereby inadequately addressing validity evidence based on test content. This dearth of missing criteria may indicate a lack of consistency between the measures and the *DSM-5* diagnostic criteria. Furthermore, the Level 2 measures focus more on specific symptoms than on actual diagnoses. For example, the CCSMs include assessments of anger, which is a symptom of many disorders in the *DSM-5*, but not a disorder itself. In addition, common psychometric properties, such as the reporting of reliability estimates of the scores, are not readily apparent, if published at all.

Therefore, standards related to the alignment of the instruments with *DSM* symptoms (i.e., evidence based on test content) are circumspect. As Helzer et al. (2006) reported, the dimensional approach to diagnosis must align with the definition of the diagnosis in the *DSM-5*.

Connecting Validity Standards to CCSMs

Pertinent to the utilization of the emerging measures for the purposes of diagnosis and clinical decision making is the extent to which the measures align with diagnostic criteria and are useful. The American Educational Research Association (AERA), the American Psychological Association, and the National Council on Measurement in Education (NCME) jointly publish the *Standards for Educational and Psychological Testing.* AERA et al. (1999) outlined issues related to instrument development, fairness and bias, and application of results to various settings (e.g., educational, vocational, psychological). With respect to evaluating research, issues of test construction, specifically evaluating validity and reliability, need to be addressed. According to AERA et al., "validity refers to the degree to which evidence and theory support the interpretations of test scores entailed by proposed uses of test" (1999, p. 9). Validity, therefore, is not simply about the alignment of an instrument with theory and research, but also about how the scores are used. The most recent edition of the standards was published in 1999, which represented the fourth edition of the joint publication and the sixth publication by at least one of the representative bodies. As of August 2013, AERA et al. approved a revision to the 1999 *Standards*; however, a publication date is pending the development of a new agreement regarding how the revised *Standards* will be managed and published (AERA et al., 2009). Thus, the 1999 *Standards* represent the most current edition for measurement guidelines.

AERA et al. (1999) identified five evidences for evaluating the validity of a measure: (a) evidence based on test content, (b) evidence based on response processes, (c) evidence based on internal structure, (d) evidence based on relationships to other variables and (e) evidence based on consequences of testing. *Evidence based on test content* is specifically related to the extent to which the items are aligned with existing theory and the operational definition of the construct. Evidence of test content often is established through documentation of a review of extant literature and expert review. *Evidence based on response processes* includes an analysis of how respondents answer or perform on given items. In counseling research, some documentation about how respondents interpret the items may be noted. *Evidence based on internal structure* refers to the psychometric properties of the instrument. For example, items on a scale should be correlated as they measure the same construct, but they should not be overly correlated, as that could indicate that the items are not measuring anything unique. Generally, factor analysis and reliability estimates are used to indicate adequate factor structure and accurate and consistent responses for scores. *Evidence based on relationships to other variables* is usually demonstrated through some type of correlational research in which the scores on an instrument are correlated with scores on another instrument. Hence, how an instrument correlates to another instrument provides evidence that the same construct is being measured. *Evidence based on consequences of testing* refers to the need to document the "intended and unintended consequences" of test scores (AERA et al., 1999, p. 16). The choice of using scores on an instrument should be aligned with theory and practice.

Evidence of Validity for the Emerging Measures

To address the psychometric properties of each of the measures is outside the scope of this article. The APA promoted various measures with common psychometric properties reported extensively in research, while other measures' psychometric properties were not as evident (Aldea, Rahman, & Storch, 2009; Allgaier, Pietsch, Frühe, Sigl-Glöckner, & Schulte-Körne, 2012; Altman, Hedeker, Peterson, & Davis, 1997; Feldman, Joormann, & Johnson, 2008; Han et al., 2009; Livianos-Aldana & Rojo-Moreno, 2001; Storch et al., 2007; Storch et al., 2009; Stringaris et al., 2012; Titov et al., 2011). From the reported measures, fairly strong psychometric properties were apparent. However, not all of the measures promoted have extensive reports (e.g., PROMIS

measures). In addition, some measures do not adequately parallel the *DSM-5* diagnoses that one might expect. The following sections include detailed comparisons of emerging measures and their corresponding *DSM-5* diagnoses. The overall purpose of this manuscript is to identify the measures' level of congruency with *DSM-5* criteria. Thus, counselors need to be aware that certain measures may provide different information about a disorder, and therefore, counselors should make informed choices regarding whether to follow the *DSM-5's* criteria. The *DSM-5* criteria are a major source for providing diagnoses; and counselors should be cautious when interpreting measures, particularly when the measures are inconsistent with *DSM-5* criteria.

Emotional Measures. When comparing the symptoms on the PROMIS Emotional Distress—Depression—Short Form (PROMIS Health Organization [PHO] and PROMIS Cooperative Group, 2012g) for adults to symptoms in the *DSM-5* on depressive disorders, the former seems to lack many crucial symptoms for depression (APA, 2013g). Containing eight statements—each asking how often the individual has been bothered by the symptom with a time period of 7 days—the measure lacks clarity as to what depression actually looks like. Common symptoms of depression such as lack of pleasure in activities, lack of appetite, weight loss, sleep loss, fatigue and thoughts of death are not addressed. The APA (2013g) noted that irritability can be a mood shown in children with the diagnoses. The parent and pediatric measures (PHO and PROMIS Cooperative Group, 2012h; 2012i) fail to include the aforementioned mood symptom, nor do they mention thoughts of death. Therefore, the *DSM-5* criteria for depression appear to be more inclusive than the PROMIS Short Form criteria.

The PROMIS Emotional Distress—Anger—Short Form, the PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric, and the PROMIS Emotional Distress—Calibrated Anger Measure—Parent (PHO and PROMIS Cooperative Group, 2012a, 2012b, 2012c) are comprised of five to six short statements (e.g. "I felt angry") completed on a 1 (*never*) to 5 (*always*) scale. Anger is included in many diagnoses, but the closest example in the *DSM-5* is the chapter titled "Disruptive, Impulse-Control, and Conduct Disorders," whose disorders can include angry moods (APA, 2013g, p. 461). Although this chapter of the *DSM-5* is most likely intended for children and adolescents, all the criteria listed in the *DSM-5* for angry/irritable mood from the diagnosis of oppositional defiant disorder (ODD) are included in the PROMIS measures for anger. Furthermore, because anger is present in many diagnoses in *DSM-5*, all measures can be helpful in providing information on anger depiction with individuals.

The PROMIS Emotional Distress—Anxiety—Short Form (PHO and PROMIS Cooperative Group, 2012d) for adults includes seven items that measure symptoms observed in an individual experiencing anxiety (e.g., "I felt anxious," "I felt fearful"). The adult measure examines both the feelings of anxiety and fear but, unlike the child measure, omits specific places or situations where fear or anxiety is experienced. The pediatric and parent measures (PHO and PROMIS Cooperative Group, 2012e, 2012f) are more detailed, examining a few situations and places (e.g., home and school) while the adult measure (PHO and PROMIS Cooperative Group, 2012d) examines only feelings associated with anxiety (e.g., fearful, anxious, worried). When comparing anxiety measures to *DSM-5* criteria, the measures lack many important criteria, particularly the adult measure which focuses on specific feelings only.

Mania is a symptom most often seen in bipolar and related disorders in the *DSM-5* (APA, 2013g). The Altman Self-Rating Mania Scale (ASRM; Altman et al., 1997) is utilized for mania depiction. The five clusters focus on happiness, self-confidence, sleep, talk and activeness. When compared to the *DSM-5* criteria for mania, the ASRM is lacking in certain areas such as distractibility, racing thoughts and high-risk activity involvement (APA, 2013g). Also, the ASRM does not address the importance of an irregular mood disturbance (i.e. elevated, expansive or irritable). The measure does not encompass all symptoms needed for mania, whereas the *DSM-5* criteria are more expansive.

Behavioral Measures. The somatic symptom measures, which were modified from the Patient Health Questionnaire Physical Symptoms (PHQ-15; Spitzer, Williams, & Kroenke, n.d.-a, n.d.-b, n.d.-c), examine different somatic symptoms and the frequency of each symptom in a given week. The modified somatic symptom measures inform the individual and his or her clinician of the severity of symptoms such as headaches, shortness of breath and stomach pain. The main difference between the symptoms measured by the scales and those discussed in the "Somatic Symptom and Related Disorders" chapter of the *DSM-5* is that the scales do not include any analysis of the excessive thoughts and feelings associated with the somatic symptoms (APA, 2013g, p. 309). The modified somatic symptom measures tell the client or clinician if and how much a symptom is present, but unlike the *DSM-5* criteria, they do not focus on the individual's actual concern over the symptom. The *DSM-5* is not focused on the child population for most somatic disorders, but it does describe the most common symptoms of somatic symptom disorder as abdominal pain, headaches, fatigue and persistent nausea. Children can exhibit somatic symptoms, but they rarely worry about these symptoms before adolescence (APA, 2013g). The adult, child and parent/guardian versions of the somatic symptom measure are similar, but with two exclusions on the child and parent/guardian version ("menstrual cramps or other problems with your periods WOMEN ONLY" and "pain or problems during sexual intercourse"; Spitzer et al., n.d.-a, n.d.-b, n.d.-c).

The PROMIS—Sleep Disturbance—Short Forms (PHO and PROMIS Cooperative Group, 2012j, 2012k, 2012l) are utilized to determine sleep issues in the past week. The measures contain such questions as "my sleep was refreshing" and "I had trouble sleeping" (PHO and PROMIS Cooperative Group, 2012j, 2012k). The sleep-wake disorders in the *DSM-5* include individual discontent with sleep, which can result in distress and impairment (APA, 2013g). Therefore, the PROMIS measures lack in that they do not have statements regarding whether the sleep disturbance is affecting the individual's life negatively. The *DSM-5* (APA, 2013g) does include different manifestations of certain symptoms for children (e.g., a child may struggle to fall asleep without a caregiver). Symptoms in children can occur because of particular situations such as inconsistent sleep schedule and conditioning issues. The onset of some sleep disorders happens in late adolescence or adulthood, with the exception of narcolepsy, which has an average onset in childhood and adolescence/young adulthood. Also, nightmare disorder happens most often in children and adolescence (APA, 2013g).

The repetitive thoughts and behaviors measures, which were adapted from the Florida Obsessive-Compulsive Inventory (FOCI) Severity Scale (Part B) and the Children's Florida Obsessive-Compulsive Inventory (C-FOCI) Severity Scale, each include five items directing the individual to rate each question. The questions are focused on time, distress, control, avoidance and interference of the thoughts or behaviors (Goodman & Storch, 1994a, 1994b). The "Obsessive-Compulsive and Related Disorders" chapter in the *DSM-5* examines main symptoms such as obsessions and compulsions (APA, 2013g, p. 235). Although the *DSM-5* specifically identifies the symptoms as obsessions and compulsions, the adaptations of the FOCI and C-FOCI identify the symptoms as simply thoughts and behaviors. The FOCI and C-FOCI include fairly similar symptoms of obsessive-compulsive disorder with simpler terms and language. The FOCI does not include the anxiety portion, but does ask about distress. Also, the FOCI and C-FOCI do not include a specific repetitive behaviors component (Goodman & Storch, 1994a, 1994b). For the most part these two measures are very similar. Each of the five questions is focused on the same topic; the minor difference is language. For example, the adult scale asks how much distress the thoughts/behaviors cause, while the child version asks how much they bother the child. The adult measure utilizes the word *work* while the child measure uses the word *job* (Goodman & Storch, 1994a, 1994b). The measures have components similar to *DSM-5* criteria, but there are inconsistencies between the two.

The Level 2—Substance Use—Adult measure, adapted from the National Institute on Drug Abuse (NIDA)-Modified ASSIST (NIDA, n.d.-a), includes 10 items that measure how often an individual used a substance in

the past two weeks. The substances included are painkillers, stimulants, sedatives or tranquilizers, marijuana, cocaine or crack, club drugs, hallucinogens, heroin, inhalants or solvents, and methamphetamine. The interviewee answers from 0–4 based on how many days the substance is used. The measure does not include alcohol, tobacco or caffeine as substances (NIDA, n.d.-a). In *DSM-5*, the chapter "Substance-Related and Addictive Disorders" focuses on substance addictions as well as process or behavioral addictions (APA, 2013g, p. 481). The Level 2—Substance Use—Adult measure and the criteria for substance use disorders in the *DSM-5* have very little in common besides the use of a substance. The *DSM-5* contains topics such as intoxication, withdrawal, social impairment, risky use, behavioral issues, psychological issues and all of their related symptoms (APA, 2013g). The possible symptoms of substance use are important to examine when treating an individual who has used a substance, and therefore the expanded criteria of the *DSM-5* are necessary. The parent and child versions (NIDA, n.d.-b, n.d.-c) of the substance use measures (15 items each) are longer than the adult version (10 items). The parent and child versions include tobacco, alcohol, steroids and other medicines, while the adult version does not. None of the above measures examine caffeine use (NIDA, n.d.-a, n.d.-b, n.d.-c).

The Swanson, Nolan, and Pelham, version IV (SNAP-IV; Swanson, 2011) for inattention in children aged 6–17 is an eight-item measure answered by a parent or guardian of the child. The items can be answered on a scale of 0 (*not at all*) to 3 (*very much*). The items center on the lack of attention to certain people, items and behaviors, such as organizing tasks, paying attention to details, and being distracted (Swanson, 2011). Inattention in children is included in the attention-deficit/hyperactivity disorder in the *DSM-5* (APA, 2013g, p. 59). Items 1–8 on the SNAP-IV (Swanson, 2011) are worded very similarly to the inattention items in the *DSM-5* (APA, 2013g), with only minor changes. The only *DSM-5* item not included in SNAP-IV regards forgetfulness of daily activities (APA, 2013g). The SNAP-IV measure and the *DSM-5* criteria appear to be relatively equal in diagnostic usefulness.

The irritability measures, identified as Affective Reactivity Index (ARI; Stringaris et al., 2012), for parent/guardian of child age 6–17 and child age 11–17, contain the same items and are rated either 0 (*not true*), 1 (*somewhat true*), or 2 (*certainly true*). Anger is a topic used in three of the seven items. Other main topics include annoyance, temper and irritability (Stringaris et. al., 2012). The irritability measures can be compared to the "Angry/Irritable Mood" section of the ODD diagnosis in *DSM-5* (APA, 2013g, p. 462). The three criteria here are included in each measure, making both resources useful.

Disorder-Specific Severity Measures. The disorder-specific severity measures are similarly complementary to diagnostic criteria in the *DSM-5* and are made for those who have met or are close to meeting a diagnosis. The two types of measures included are self-administered (adult and child age 11–17) and clinician-administered. Disorders included in the self-administered measures are depression, separation anxiety disorder, specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, generalized anxiety disorder, post-traumatic stress symptoms, acute stress symptoms, and dissociative symptoms (APA, 2014). Disorders and symptoms included in the clinician-administered measures are autism spectrum and social communication disorders, psychosis symptoms, somatic symptom disorder, ODD, conduct disorder, and nonsuicidal self-injury (APA, 2013b, 2013a, 2013f, 2013e, 2013c, 2013d).

Generally, the disorder-specific severity measures have a different time frame for meeting criteria for symptoms than the *DSM-5* does and do not discuss significant distress or proportion to danger. Few, if any, differences exist between the adult and child measures. The clinician-rated measures are short and lack clarity on definitions. For example, the measures on ODD as well as nonsuicidal self-injury do not include the construct definitions (APA, 2013e, 2013d).

Self-Administered Measures. The Severity Measure for Depression—Adult and Severity Measure for Depression—Child Age 11–17 (Spitzer et al., n.d.-d, 2002), which were adapted from the Patient Health Questionnaire-9 (PHQ-9), include nine items rated from 0 (*not at all*) to 3 (*nearly every day*) with a time period of the past 7 days. The first two items on these measures are similar to the first two symptoms needed for major depressive disorder in the *DSM-5*, both referring to depressed mood and decreased interest or pleasure (APA, 2013g). These measures include somewhat of a weight component similar to that of the *DSM-5*, although the weight items on the measures examine appetite/overeating, while symptoms in the *DSM-5* examine an extra component of weight loss/gain or appetite changes. The components regarding sleeping and psychomotor symptoms, fatigue, worthlessness, concentration and thoughts of death on the measures are all similar to criteria in the *DSM-5*, although worded differently. Irritability is added to an item on the child measure (Spitzer et al., 2002), but was not included in the adult measure (Spitzer et al., n.d.-d). The child measure's item on eating refers to "poor appetite, weight loss, or overeating," (Spitzer et al., 2002) whereas the adult measure does not mention weight loss (Spitzer et al., n.d.-d); similarly, one *DSM-5* criterion for major depressive disorder states, "in children, consider failure to make expected weight gain" (APA, 2013g, p. 161). In spite of a few differences, the Severity Measures for Depression are mostly consistent with *DSM-5* criteria for major depressive disorder.

The Severity Measure for Separation Anxiety Disorder—Adult and Severity Measure for Separation Anxiety Disorder—Child Age 11–17 (Craske et al., 2013g, 2013h) include 10 items examining the past 7 days based on a scale of 0 (*never*) to 4 (*all of the time*). The statements focus on separation and thoughts, behaviors and feelings behind the separation (Craske et al., 2013g, 2013h). The 10 items from the measure are mostly similar to criteria for separation anxiety disorder in the *DSM-5* (APA, 2013g). Items 1 and 2 on the measures (which refer to terror, fear, fright, anxiety, worry and nervousness) appear similar to the distress from separation criteria in the *DSM-5* with different wording. Thoughts of bad things happening, avoidance of places, physical symptoms of anxiety and difficulty sleeping are similar criteria to those in the *DSM-5*. The four items included in the measures but not in the *DSM-5* criteria are as follows: "when separated, left places early to go home," "spent a lot of time preparing for how to deal with separation," "distracted myself to avoid thinking about being separated," and "needed help to cope with separation" (Craske et al., 2013g, 2013h). Although these measures and the *DSM-5* contain similar criteria for separation anxiety disorder, the measure includes items that may not be congruent to *DSM-5* criteria.

The Severity Measure for Specific Phobia—Adult and Severity Measure for Specific Phobia—Child Age 11–17 (Craske et al., 2013k, 2013l) have 10 items that include five different groups of phobias, including (a) driving, flying, tunnels, bridges or enclosed spaces; (b) animals or insects; (c) heights, storms or water; (d) blood, needles or injections; and (e) choking or vomiting. The individual completing the form chooses one phobia and answers items according to that phobia on a scale of 0 (*never*) to 4 (*all of the time*; Craske et al., 2013k, 20131). The measures include more items than the criteria in the *DSM-5*. Items 1 and 2 (terror, fear, fright; anxiety, worry, nervousness) on the measures resemble criterion A (fear or anxiety) in the *DSM-5* for specific phobia (APA, 2013g, p. 197). Physical symptoms (e.g., racing heart, tense muscles) are not included in the *DSM-5* criteria. Avoidance of a situation is included both in the measures and in the *DSM-5*. The items in the measures which are not included in the *DSM-5* are "spent a lot of time preparing for, or procrastinating about (i.e., putting off), these situations," "distracted myself to avoid thinking about these situations" and "needed help to cope with these situations" (Craske et al., 2013k, 2013l). The specifiers in the *DSM-5* (animal, natural environment, blood-injection-injury, situational and other) are similar to phobias included in the measures (APA, 2013g, p. 198). The *DSM-5* states that "in children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging" (APA, 2013g, p. 197), and this information is not included in the child version of this measure.

The Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult and Severity Measure for Social Anxiety Disorder (Social Phobia)—Child Age 11–17 (Craske et al., 2013i, 2013j) are 10-item measures completed on a scale of 0 (*never*) to 4 (*all of the time*). The social situations described in the measures are the same as those described in the *DSM-5* for social anxiety disorder (social phobia; APA, 2013g). Items 1, 2 and 3 on the measures are similar to criteria A and B in the *DSM-5*. Physical symptoms such as racing heart and tense muscles are included in the measures but are not included in the *DSM-5* criteria. Avoidance of social situations is included in both the measures and the *DSM-5* criteria. There are items included in the measures that are not included in the *DSM-5* criteria, such as "spent a lot of time preparing what to say or how to act in social situations" and "distracted myself to avoid thinking about social situations" (Craske et al., 2013i, 2013j). One *DSM-5* criterion states that "the social situations almost always provoke fear or anxiety" (APA, 2013g, p. 202), an item which is not present in the measures. In the *DSM-5* there are a few differences for children with social anxiety disorder. Anxiety has to take place with peers and not only with adults. Furthermore, fear/anxiety can be expressed through crying, tantrums, freezing, clinging, shrinking or not speaking. These differences are not included in the child version of the measure (Craske et al., 2013j).

The Severity Measure for Panic Disorder—Adult and Severity Measure for Panic Disorder—Child Age 11–17 (Craske et al., 2013e, 2013f) are 10-item measures completed on a scale of 0 (*never*) to 4 (*all of the time*). The measures provide a definition and the symptoms of a panic attack in an individual (Craske et al., 2013e, 2013f). This information is similar to the definition of panic disorder in the *DSM-5* (APA, 2013g). The measures include six of the 13 symptoms included in the *DSM-5*. Items on the measures that are not included in the *DSM-5* criteria include "left situations early, or participated only minimally, because of panic attacks," "spent a lot of time preparing for, or procrastinating about (putting off), situations in which panic attacks might occur," "distracted myself to avoid thinking about panic attacks" and "needed help to cope with panic attacks" (Craske et al., 2013e, 2013f). The *DSM-5* includes certain symptoms that the measures do not, including choking feelings, pain in chest, nausea, sensations of chills or heat, sensations of numbness or tingling, and derealization or depersonalization (APA, 2013g, p. 208). The measures have an item on sleeping issues, which was not included in the *DSM-5*.

The Severity Measure for Agoraphobia—Adult and Severity Measure for Agoraphobia—Child Age 11–17 (Craske et al., 2013a, 2013b) are 10-item measures to be completed on a scale of 0 (*never*) to 4 (*all of the time*). The instructions for the measures include situations on which to base the items (e.g., being in crowds or public spaces, traveling). The criteria for agoraphobia in the *DSM-5* include significant distress caused by at least two of the following five situations: "being outside of the home alone," "using public transportation," "standing in line or being in a crowd" and being in "open spaces" and/or "enclosed spaces" (APA, 2013g, p. 217). The fear and anxiety experienced and the avoidance of situations are included in both the measures and the *DSM-5* criteria. Although avoidance is included in the measures, the reason for the avoidance is not. Items included in the measures but not in the *DSM-5* criteria include "had thoughts about panic attacks, uncomfortable physical sensations, getting lost, or being overcome with fear in these situations"; "spent a lot of time preparing for, or procrastinating about (putting off), these situations"; "distracted myself to avoid thinking about these situations"; and "needed help to cope with these situations" (Craske et al., 2013a, 2013b). Also, two items on physical sensations from the measures are not present in the *DSM-5* criteria (APA, 2013g; Craske et al., 2013a, 2013b).

The Severity Measure for Generalized Anxiety Disorder—Adult and Severity Measure for Generalized Anxiety Disorder—Child Age 11–17 (Craske et al., 2013c, 2013d) are 10-item scales completed on a scale from 0 (*never*) to 4 (*all of the time*). Differences are found when comparing the measures to generalized anxiety disorder in the *DSM-5* (APA, 2013g). The measures do not include the following *DSM-5* criteria: anxiety

and worry occurring for 6 months or more, difficulty controlling worry, the anxiety and worry perhaps being associated with difficulty concentrating and irritability, and the anxiety and worry causing distress (APA, 2013g, p. 222). The measures include the following items that the *DSM-5* does not: "avoided, or did not approach or enter, situations about which I worry"; "left situations early or participated only minimally due to worries"; "spent lots of time making decisions, putting off making decisions, or preparing for situations, due to worries"; "sought reassurance from others due to worries"; and "needed help to cope with anxiety" (Craske et al., 2013c, 2013d). Also, item 3 on the measures ("had thoughts of bad things happening") is similar to criterion A in the *DSM-5* ("anxiety and worry . . . about a number of events or activities") with different wording (APA, 2013g, p. 222; Craske et al., 2013c, 2013d).

The National Stressful Events Survey PTSD Short Scale (NSESSS; Kilpatrick, Resnick, & Friedman, 2013c) contains nine items and is to be completed on a scale of 0 (*not at all*) to 4 (*extremely*). The criteria for post-traumatic stress disorder (PTSD) in the *DSM-5* include a list of possible stressful events and situations (APA, 2013g). The NSESSS does not include a list of stressful events and situations for the individual. Criteria and items that are the same or similar on the NSESSS and in *DSM-5* PTSD criteria include flashbacks, emotional (NSESSS) or psychological distress (*DSM-5*), avoidance, negative feelings about self, distorted cognitions and blame, negative emotional states, loss of interest in activities, anger and irritability, self-destructive behavior, hypervigilance and startle response (APA, 2013g; Kilpatrick et al., 2013c). The items/criteria may be worded and/or organized differently but they have the same meaning. Although all items on the NSESSS are included in the *DSM-5's* criteria for PTSD, the *DSM-5* includes additional criteria beyond what the NSESSS measures, which suggests the *DSM-5* as being more thorough of the two, and indicates the inconsistencies of the NSESSS when compared to the *DSM-5* criteria. The following criteria from the *DSM-5* are not included in the NSESSS: dreams, physiological reactions, dissociative amnesia, detachment/estrangement from others, inability to experience positive emotions, concentration issues and sleep issues. There are notes in the *DSM-5* for application to children. Children may partake in recurring play/reenactment having to do with the traumatic event. Dreams with unrecognizable content may occur (APA, 2013g). The criteria above were not included in the child version of the NSESSS (Kilpatrick, Resnick, & Friedman, 2013d). Also, the *DSM-5* has a different section for children 6 and under, but the NSESSS is to be completed by children 11–17 (APA, 2013g; Kilpatrick et al., 2013d).

The National Stressful Events Survey Acute Stress Disorder Short Scale (NSESSS; Kilpatrick et al., 2013a) for severity of acute stress symptoms includes seven items and is to be completed on a scale of 0 (*not at all*) to 4 (*extremely*). Six out of the seven items on this measure are the same as those on the measure for PTSD above. Items that are also included in acute stress disorder in the *DSM-5* are flashbacks, emotional (NSESSS) or psychological distress (*DSM-5*), detachment, avoidance, hypervigilance, startle response and irritability/anger (APA, 2013g). Similar to the NSESSS for PTSD, all seven items on the NSESSS for acute stress disorder are included in the *DSM-5* criteria, but certain *DSM-5* criteria are not included in the NSESSS. The criteria not included are as follows: dreams, inability to experience positive emotions, dissociative amnesia, sleep disturbance and concentration issues. There are notes in the *DSM-5* for application to children. Children may partake in recurring play/reenactment having to do with the traumatic event. Dreams with unrecognizable content may occur. The criteria above were not included in the child version of the NSESSS (Kilpatrick et al., 2013b). Neither of the NSESSS measures fully assess an individual for the *DSM-5* criteria for PTSD or acute stress disorder.

The Brief Dissociative Experiences Scale (DES-B)—Modified (Dalenberg & Carlson, 2010a) has eight items and is completed on a scale of 0 (*not at all*) to 4 (*more than once a day*) in the past 7 days. When comparing this measure to dissociative disorders in the *DSM-5*, it is hard to find a specific criterion that matches closely to

items on the scale (APA, 2013g, p. 291). The closest criterion is found under dissociative identity disorder (DID; APA, 2013g). Although the wording is different, disruption of identity and gaps in recollections are both present in the DES-B and *DSM-5* criteria for DID. Some items on the DES-B are also included in depersonalization/derealization disorder (APA, 2013g, p. 302). Both depersonalization and derealization symptoms are included in DES-B. There is one note under DID in the *DSM-5* applicable to children: symptoms in children are not better justified by imaginary or fantasy play. This is not included in the child version of the DES-B (Dalenberg & Carlson, 2010b). Although items included in the measures are present in *DSM-5* criteria, overall, the measures are inconsistent with *DSM-5* criteria.

Clinician-Rated. The Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders is a measure that assesses "the level of interference in functioning and support required as a result of: a) any social communication problems AND b) any restricted interests and repetitive behaviors" (APA, 2013b). The two disorders included are autism spectrum disorder (APA, 2013g, p. 50) and social (pragmatic) communication disorder (APA, 2013g, p. 47). The clinician must choose one of these disorders. The clinician rates the two items above (social communication and restricted interests /repetitive behaviors) based on levels 0 (*none*), 1 (*mild; requiring support*), 2 (*moderate; requiring substantial support*), and 3 (*severe; requiring very substantial support*). The measure does not go into detail about these disorders' diagnostic criteria, but the *DSM-5* offers a detailed account (APA, 2013b, 2013g). Besides simply stating the two issues above, the measure fails to include specific criteria from the *DSM-5.*

The Clinician-Rated Dimensions of Psychosis Symptom Severity (APA, 2013a) is a measure that rates symptoms of psychosis based on presence and severity in the last 7 days. The eight domains included in the measure are hallucinations, delusions, disorganized speech, abnormal psychomotor behavior, negative symptoms (restricted emotional expression or avolition), impaired cognition, depression and mania. The clinician rates the symptoms either 0 (*not present*), 1 (*equivocal*), 2 (*present, but mild*), 3 (*present and moderate*) or 4 (*present and severe*; APA, 2013a). According to the *DSM-5*, the five main features of psychotic disorders include delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms (APA, 2013g, pp. 96, 99). These main features are included in the measure as well as three others. Schizophreniform disorder (APA, 2013g, p. 96) and schizophrenia (APA, 2013g, p. 99) include the five main features for criteria in the *DSM-5* but not the last three included in the measure, which are impaired cognition, depression and mania (APA, 2013a). Other disorders, such as depressive or bipolar disorders with psychotic features, would include either a depressive or manic symptom (APA, 2013g, 2013a). Because the measure assesses psychosis symptoms that are consistent with *DSM-5,* this measure could be useful in determining severity but not consistent with any specific diagnosis.

The Clinician-Rated Severity of Somatic Symptom Disorder (APA, 2013f) includes three items in which the clinician rates somatic symptoms based on presence and severity in the last 7 days. The scale is to be completed from 0 (*not at all*) to 4 (*very much*). The main themes of the three questions are concerns, anxiety, and time and energy (APA, 2013f). The somatic symptom disorder in the *DSM-5* includes the three themes above in criterion B with similar wording, but also includes criteria not present in the measure (APA, 2013g, p. 311), so the measure is again inconsistent with *DSM-5* criteria.

The Clinician-Rated Severity of ODD (APA, 2013e) and the Clinician-Rated Severity of Conduct Disorder (APA, 2013c) both include only one item to assess based on the presence and severity of any ODD or conduct disorder symptoms (APA, 2013g). The scales are to be completed from level 0 (*none*) to level 3 (*severe*). The items simply state, "Rate the level or severity of the OPPOSITIONAL DEFIANT problems that are present for this individual" (APA, 2013e) and "Rate the level or severity of the conduct problems that are present for this

individual" (APA, 2013c). The criteria for diagnosis are not listed in the measures but can be found under ODD and conduct disorder in the *DSM-5* (APA, 2013g). Although the criteria for both are absent in the measures, APA refers clinicians to the *DSM-5,* which suggests that the measures completely parallel the diagnostic criteria.

The Clinician-Rated Severity of Nonsuicidal Self-Injury (APA, 2013d) is a one-item measure that examines the presence and severity of any nonsuicidal self-injury problems that have happened in the past year. The scale is to be completed based on five levels, including 0 (*none*), 1 (*subthreshold*), 2 (*mild*), 3 (*moderate*), and 4 (*severe*). The item simply states, "Rate the level or severity of the NONSUICIDAL SELF-INJURY problems that are present for this individual" (APA, 2013d). The symptoms are not listed but can be found under nonsuicidal self-injury in the *DSM-5* (APA, 2013g, p. 803). Similarly to the previous measures stated, the APA directs clinicians to the *DSM-5,* which again indicates an alignment to diagnostic criteria.

Implications for Counseling Practice

The APA (2013g) endorsed dimensional assessment to be used in conjunction with categorical diagnoses. An effort to establish measurement protocols in a process often deemed rather subjective is laudable. The APA indicated that the assessment system was an "emerging" (2013g, p. 729) system, which indicates a rather circumspect decision by the APA. The *DSM* system represents a system of classifying diagnoses, whose current framework is 20–30 years old and widely established (Jones, 2012). Given the influence of the *DSM* system of diagnosis (e.g., reimbursement, research studies, treatment planning), the publication of the emerging measures that fail to meet basic standards of testing and measurement could be confusing to counselors expecting that scores of the emerging measures would provide consistent and accurate information about severity and be consistent with diagnostic classifications in the *DSM-5*.

The presence of validity evidence across the emerging measures is inconsistent, based on erratic reporting of psychometric information and lack of alignment with diagnostic criteria, such as what was documented regarding the disorder-specific severity measures. Although many of the measures were validated for clinical use, other measures lack this information. Perhaps the most basic critique of the system is that the publication of these measures lack alignment with the very diagnostic categories they are supposed to evaluate.

Evidence based on test content (AERA et al., 1999) is perhaps the most basic type of evidence for providing validity evidence of measures. The process entails that instruments that are developed be aligned with published research and expert review. Hence, the presence of dimensional measures that are supposed to align with the *DSM-5* classification system but fail to be comprehensive in the breadth of symptoms covered could be a serious limitation of these emerging measures.

Professional counselors should be cautious in the adoption of the dimensional measures. Many quality measures already exist that adequately align with the categorical diagnostic system of the APA. For example, in the development of the Beck Depression Inventory (BDI)-II, Beck, Steer, and Brown (1996) updated the initial BDI to align with the diagnostic symptoms of depression used in the *DSM-IV*. The APA should follow similar processes in terms of content alignment and the collection and analysis of data to provide evidence of psychometric properties; counselors must be aware that adherence to this process was not systematically implemented. Both the CCSMs and severity measures were designed to review general symptoms commonly apparent across a broad range of clients and to "be administered both at initial interview and over time to track the patient's symptom status and response to treatment" (APA, 2013g, p. 733). However, the variability with respect to the diagnostic classifications and absence of psychometric properties limits the potential for these measures to provide accurate and valid assessments.

The measures may be helpful in confirming clinical impressions or identifying potential problem areas that warrant further exploration. To some degree, however, counselors should be aware of potential ethical dilemmas that could arise from using the emerging measures endorsed by the APA. According to the American Counseling Association (ACA), "counselors have a responsibility to the public to engage in counseling practices that are based on rigorous research methodologies" (2014, p. 8). Clearly, the extent to which the published emerging measures represent rigorous research is at issue. APA does identify the measures as "emerging" (2013g, p. 729), thereby acknowledging the preliminary nature of the dimensional assessments. From a public health standpoint, the consequences of basing diagnoses or justifying clinical care or improvement solely on the emerging measures could be egregious. As third-party payers and managed care companies scramble to adopt the new classification system, the presence of the emerging measures could be mistaken as an endorsement for their adoption by organizations (e.g., managed care companies) that lack the understanding of the measurement and evaluation principles. The presence of the emerging measures in the *DSM-5* presents an incomplete system that may not augment comprehensively the categorical system of diagnosis currently endorsed by the APA (2013g). Counselors using the emerging measures should employ other well-established measures and protocols to corroborate their clinical impressions and findings.

Counselors should be careful when interpreting the results of instruments that lack adequate empirical data to support respondent results; they should also qualify any conclusions, diagnoses, or recommendations that are based on assessments or instruments (ACA, 2014, p. 12). When emerging measures are used for diagnostic classification or to denote changes in symptoms or distress, counselors should identify the extent to which the findings from the dimensional assessment match the clinical impressions or findings from other assessment tools. Assessment tools, in general, provide information that should not stand alone (Balkin & Juhnke, 2014), and the use of the dimensional measures is not an exception to this rule.

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References

Aldea, M. A., Rahman, O., & Storch, E. A. (2009). The psychometric properties of the Florida Obsessive Compulsive Inventory: Examination in a non-clinical sample. *Individual Differences Research*, *7*, 228–238.

Allgaier, A.-K., Pietsch, K., Frühe, B., Sigl-Glöckner, J., & Schulte-Körne, G. (2012). Screening for depression in adolescents: Validity of the patient health questionnaire in pediatric care. *Depression and Anxiety*, *29*, 906–913. doi:10.1002/da.21971

Altman, E. G., Hedeker, D., Peterson, J. L., & Davis, J. M. (1997). The Altman Self-Rating Mania Scale. *Biological Psychiatry*, *42*, 948–955.

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association.

American Educational Research Association, American Psychological Association, & National Council on Measurement in Education. (2009). *Standards for educational and psychological testing*. Retrieved from http://www.teststandards.org

American Psychiatric Association. (2013a). *Clinician-Rated Dimensions of Psychosis Symptom Severity* [Measurement

instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
American Psychiatric Association. (2013b). *Clinician-Rated Severity of Autism Spectrum and Social Communication Disorders* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
American Psychiatric Association. (2013c). *Clinician-Rated Severity of Conduct Disorder* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
American Psychiatric Association. (2013d). *Clinician-Rated Severity of Nonsuicidal Self-Injury* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
American Psychiatric Association. (2013e). *Clinician-Rated Severity of Oppositional Defiant Disorder* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
American Psychiatric Association. (2013f). *Clinician-Rated Severity of Somatic Symptom Disorder* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
American Psychiatric Association. (2013g). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.
American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Balkin, R. S., & Juhnke, G. A. (2014). *The theory and practice of assessment in counseling.* Boston, MA: Pearson.
Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II manual*. San Antonio, TX: The Psychological Corporation.
Bjelland, I., Lie, S. A., Dahl, A. A., Mykletun, A., Stordal, E., & Kraemer, H. C. (2009). A dimensional versus a categorical approach to diagnosis: Anxiety and depression in the HUNT 2 study. *International Journal of Methods in Psychiatric Research*, *18*, 128–137. doi:10.1002/mpr.284
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013a). *Severity Measure for Agoraphobia—Adult* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013b). *Severity Measure for Agoraphobia—Child Age 11–17* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013c). *Severity Measure for Generalized Anxiety Disorder—Adult* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013d). *Severity Measure for Generalized Anxiety Disorder—Child Age 11–17* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013e). *Severity Measure for Panic Disorder—Adult* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013f). *Severity Measure for Panic Disorder—Child Age 11–17* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013g). *Severity Measure for Separation Anxiety Disorder—Adult* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013h). *Severity Measure for Separation Anxiety Disorder—Child Age 11–17* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013i). *Severity Measure for Social Anxiety Disorder (Social Phobia)—Adult* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures
Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013j). *Severity Measure for Social Anxiety Disorder (Social Phobia)—Child Age 11–17* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013k). *Severity Measure for Specific Phobia—Adult* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Craske, M., Wittchen, U., Bogels, S., Stein, M., Andrews, G., & Lebeu, R. (2013l). *Severity Measure for Specific Phobia—Child Age 11–17* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Dalenberg, C., & Carlson, E. (2010a). *Severity of Dissociative Symptoms—Adult (Brief Dissociative Experiences Scale [DES-B]—Modified)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Dalenberg, C., & Carlson, E. (2010b). *Severity of Dissociative Symptoms—Child Age 11–17 (Brief Dissociative Experiences Scale [DES-B]—Modified)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Feldman, G. C., Joormann, J., & Johnson, S. L. (2008). Responses to positive affect: A self-report measure of rumination and dampening. *Cognitive Therapy and Research*, *32*, 507–525. doi:10.1007/s10608-006-9083-0

Goodman, W. K., & Storch, E. (1994a). *LEVEL 2—Repetitive Thoughts and Behaviors—Adult (Adapted from the Florida Obsessive-Compulsive Inventory [FOCI] Severity Scale [Part B])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Goodman, W. K., & Storch, E. (1994b). *LEVEL 2—Repetitive Thoughts and Behaviors—Child Age 11–17 (Adapted from the Children's Florida Obsessive-Compulsive Inventory [C-FOCI] Severity Scale)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Han, C., Pae, C.-U., Patkar, A. A., Masand, P. S., Kim, K. W., Joe, S.-H., & Jung, I.-K. (2009). Psychometric properties of the patient health questionnaire-15 (PHQ-15) for measuring the somatic symptoms of psychiatric outpatients. *Psychosomatics*, *50*, 580–585.

Helzer, J. E., van den Brink, W., & Guth, S. E. (2006). Should there be both categorical and dimensional criteria for the substance use disorders in DSM-V? [Suppl. S1]. *Addiction*, *101*, 17–22. doi:10.1111/j.1360-0443.2006.01587.x

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development*, *90*, 481–487. doi:10.1002/j.1556-6676.2012.00059.x

Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013a). *Severity of Acute Stress Symptoms—Adult (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESSS])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013b). *Severity of Acute Stress Symptoms—Child Age 11–17 (National Stressful Events Survey Acute Stress Disorder Short Scale [NSESSS])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013c). *Severity of Posttraumatic Stress Symptoms—Adult (National Stressful Events Survey PTSD Short Scale [NSESSS])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Kilpatrick, D. G., Resnick, H. S., & Friedman, M. J. (2013d). *Severity of Posttraumatic Stress Symptoms—Child Age 11–17 (National Stressful Events Survey PTSD Short Scale [NSESSS])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Kraemer, H. C., Noda, A., & O'Hara, R. (2004). Categorical versus dimensional approaches to diagnosis: Methodological challenges. *Journal of Psychiatric Research*, *38*, 17–25. doi:10.1016/S0022-3956(03)00097-9

Livesley, W. (2007). A framework for integrating dimensional and categorical classifications of personality disorder. *Journal of Personality Disorders*, *21*, 199–224.

Livianos-Aldana, L., & Rojo-Moreno, L. (2001). Rating and quantification of manic syndromes [Suppl. 409]. *Acta Psychiatrica Scandinavica*, *104*, 2–33.

National Institute on Drug Abuse. (n.d.-a). *Level 2—Substance Use—Adult (Adapted from the NIDA-Modified ASSIST)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

National Institute on Drug Abuse. (n.d.-b). *Level 2—Substance Use—Child Age 11–17 (Adapted from the NIDA-Modified ASSIST)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

National Institute on Drug Abuse. (n.d.-c). *Level 2—Substance Use—Parent/Guardian of Child Age 6–17 (Adapted from the NIDA-Modified ASSIST)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012a). *LEVEL 2—Anger—Adult (PROMIS Emotional Distress—Anger—Short Form)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012b). *LEVEL 2—Anger—Child Age 11–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Pediatric)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012c). *LEVEL 2—Anger—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Calibrated Anger Measure—Parent)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012d). *LEVEL 2—Anxiety—Adult (PROMIS Emotional Distress—Anxiety—Short Form)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012e). *LEVEL 2—Anxiety—Child Age 11–17 (PROMIS Emotional Distress—Anxiety—Pediatric Item Bank)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012f). *LEVEL 2—Anxiety—Parent/Guardian of Child Age 6–17 (Adapted from PROMIS Emotional Distress—Anxiety—Parent Item Bank)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012g). *LEVEL 2—Depression—Adult (PROMIS Emotional Distress—Depression—Short Form)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012h). *LEVEL 2—Depression—Child Age 11–17 (PROMIS Emotional Distress—Depression—Pediatric Item Bank)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012i). *LEVEL 2—Depression—Parent/Guardian of Child Age 6–17 (PROMIS Emotional Distress—Depression—Parent Item Bank)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012j). *Level 2—Sleep Disturbance—Adult (PROMIS—Sleep Disturbance—Short Form)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012k). *Level 2—Sleep Disturbance—Child Age 11–17 (PROMIS—Sleep Disturbance—Short Form)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

PROMIS Health Organization and PROMIS Cooperative Group. (2012l). *Level 2—Sleep Disturbance—Parent/Guardian of Child Age 6–17 (PROMIS—Sleep Disturbance—Short Form)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-a). *Level 2—Somatic Symptom—Adult Patient (Adapted from the Patient Health Questionnaire Physical Symptoms [PHQ-15])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-b). *Level 2—Somatic Symptom—Child Age 11–17 (Adapted from the Patient Health Questionnaire Physical Symptoms [PHQ-15])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-c). *Level 2—Somatic Symptom—Parent/Guardian of Child Age 6–17 (Adapted from the Patient Health Questionnaire Physical Symptoms [PHQ-15])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (n.d.-d). *Severity Measure for Depression—Adult (adapted from the Patient Health Questionnaire–9 [PHQ-9])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Spitzer, R. L., Williams, J. B. W., & Kroenke, K. (2002). *Severity Measure for Depression—Child Age 11–17 (PHQ-9 modified for Adolescents [PHQ-A]—Adapted)* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Stewart, J. A., Deliyannides, D. A., Hellerstein, D. J., McGrath, P. J., & Stewart, J. W. (2012). Can people with nonsevere major depression benefit from antidepressant medication? *The Journal of Clinical Psychiatry*, *73*, 518–525. doi:10.4088/JCP.10m06760

Storch, E. A., Bagner, D., Merlo, L. J., Shapira, N. A., Geffken, G. R., Murphy, T. K., & Goodman, W. K. (2007). Florida Obsessive-Compulsive Inventory: Development, reliability, and validity. *Journal of Clinical Psychology*, *63*, 851–859. doi:10.1002/jclp.20382

Storch, E. A., Khanna, M., Merlo, L. J., Loew, B. A., Franklin, M., Reid, J. M., . . . Murphy, T. K. (2009). Children's Florida Obsessive Compulsive Inventory: Psychometric properties and feasibility of a self-report measure of obsessive–compulsive symptoms in youth. *Child Psychiatry and Human Development*, *40*, 467–483. doi:10.1007/s10578-009-0138-9

Stringaris, A., Goodman, R., Ferdinando, S., Razdan, V., Muhrer, E., Leibenluft, E., & Brotman, M. A. (2012). The Affective Reactivity Index: A concise irritability scale for clinical and research settings. *Journal of Child Psychology and Psychiatry*, *53*, 1109–1117. doi:10.1111/j.1469-7610.2012.02561.x

Swanson, J. M. (2011). *LEVEL 2—Inattention—Parent/Guardian of Child Age 6–17 (Swanson, Nolan, and Pelham, version IV [SNAP-IV])* [Measurement instrument]. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Titov, N., Dear, B. F., McMillan, D., Anderson, T., Zou, J., & Sunderland, M. (2011). Psychometric comparison of the PHQ-9 and BDI-II for measuring response during treatment of depression. *Cognitive Behaviour Therapy*, *40*, 126–136. doi:10.1080/16506073.2010.550059

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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References

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Clarke, D. E. (2013, May). DSM-5 Adult Patient-Rated, Cross-Cutting Dimensional Measures: Reliability, Sensitivity to Change, and Association With Disability in the DSM-5 Adult Female. In W. Narrow & N. Sartorius (Chairs), Symptoms and Disability Measures in DSM-5. Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

Colom, F., Vieta, E., Martínez-Arán, A., Reinares, M., Benabarre, A., & Gastó, C. (2000). Clinical factors associated with treatment noncompliance in euthymic bipolar patients. *Journal of Clinical Psychology*, *61*, 549–555.

Coryell, W. (2013, May). Specifier for major depressive episodes in DSM-5. In L. Davis & J. Fawcett (Chairs), *DSM-5 and major depression.* Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

Goldberg, D. P. (2013, May). The importance of anxiety in common forms of depressive illness. In L. Davis & J. Fawcett (Chairs), *DSM-5 and major depression.* Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

Kreyenbuhl, J., Nossel, I. R., & Dixon, L. B. (2009). Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: A review of the literature. *Schizophrenia Bulletin*, *35*, 696–703.

Malaspina, D. (2013, May). Relationships between the dimensions and behavioral constructs in the DSM-5 Psychosis Chapter with the considerations of the NIMH Rdoc initiative. In W. T. Carpenter & R. Tandon (Chairs), *DSM-5 psychosis chapter*. Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

Merikangas, K. R., Akiskal, H. S., Angst, J., Greenberg, P. E., Hirschfeld, R. M. A., Petukhova, M., & Kessler, R. C. (2007). Lifetime and 12-Month Prevalence of Bipolar Spectrum Disorder in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *64*, 543–553. doi:10.1001/archpsyc.64.5.543

National Alliance on Mental Illness. (2014). *Assertive Community Treatment (ACT)*. Retrieved from http://www.nami.org/template.cfm?section=ACT-TA_Center

National Institute of Mental Health. (n.d.-a). Depression. Retrieved from http://www.nimh.nih.gov/health/topics/depression

National Institute of Mental Health. (n.d.-b). Bipolar Disorder. Retrieved from http://www.nimh.nih.gov/health/topics/bipolar-disorder

National Institute of Mental Health. (n.d.-c). Schizophrenia. Retrieved from http://www.nimh.nih.gov/health/topics/schizophrenia

Paradise, L. V., & Kirby, P. C. (2005). The treatment and prevention of depression: Implications for counseling and counselor training. *Journal of Counseling & Development*, *83*, 116–119. doi:10.1002/j.1556-6678.2005.tb00586.x

Phillips, M. R. (2013, May). Rethinking Depressive NOS Conditions and Suicidality in DSM-5. In L. Davis & J. Fawcett (Chairs), *DSM-5 and major depression*. Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

Salyers, M. P., & Tsemberis, S. (2007). ACT and recovery: Integrating evidence-based practice and recovery orientation on Assertive Community Treatment teams. *Community Mental Health Journal*, *43*, 619–641. doi:10.1007/s10597-007-9088-5

Steinkuller, A., & Rheineck, J. E. (2009). A review of evidence-based therapeutic interventions for bipolar disorder. *Journal of Mental Health Counseling*, *31*, 338–350.

Substance Abuse and Mental Health Services Administration. (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*. Retrieved from http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm#sec2-1

Tandon, R. (2013, May). Conceptual and criteria changes from DSM-IV. In W. T. Carpenter & R. Tandon (Chairs), *DSM-5 psychosis chapter*. Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

Zisook, S. (2013, May). The bereavement exclusion. In L. Davis & J. Fawcett (Chairs), *DSM-5 and major depression*. Symposium conducted at the meeting of the American Psychiatric Association, San Francisco, CA.

The Expansion and Clarification of Feeding and Eating Disorders in the *DSM-5*

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) introduced a chapter titled "Feeding and Eating Disorders," which takes a life-span approach to diagnosing eating disorders and contains all related diagnoses. Rather than appearing throughout the text, all eating disorders are now contained within their own chapter for ease of review and comparison. Changes to the feeding and eating disorders include diagnostic revisions and the addition of several new disorders, including avoidant/restrictive food intake disorder and binge-eating disorder. While pica and rumination disorder remain unchanged, anorexia nervosa and bulimia nervosa experience some criteria changes. There is now a system for classifying the severity of several eating disorders (mild, moderate and severe) and an emphasis on body mass index for the diagnosis of anorexia nervosa. The *DSM-5* also attempted to address the number of cases of eating disorders that did not meet criteria in any one category (e.g., eating disorder not otherwise specified), and the authors discuss the result of this attempt in examining two new disorders. This paper examines these changes and addresses clinical implications, while alerting counselors to important diagnostic information.

Keywords: **eating disorders, *DSM-5*, pica, anorexia nervosa, bulimia nervosa, binge eating**

With the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association [APA], 2013a) in May 2013 came structural changes to the categorization of disorders as well as criteria changes to a variety of disorders. One diagnostic category that experienced multiple changes is eating disorders. As stated in the *DSM-5*, "feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning" (APA, 2013a, p. 329). Previously spread throughout several chapters in the *DSM*, these disorders are now self-contained in a single, more comprehensive chapter titled "Feeding and Eating Disorders." This revised diagnostic category includes several new disorders and reflects changes to the criteria and wording of some existing diagnoses. While some of the changes are minor, all are noteworthy (Hartmann, Becker, Hampton, & Bryant-Waugh, 2012) and warrant examination. This article seeks to highlight the changes to this category and assist counselors in a greater understanding of these updated diagnoses.

Prevalence of Eating Disorders

One study by Hudson, Hiripi, Pope, and Kessler (2007) used data from the National Comorbidity Survey Replication to generate estimates of the prevalence of anorexia nervosa (AN), bulimia nervosa (BN) and binge-eating disorder (BED) among adults in the United States. The researchers based these estimates on the criteria found in the *DSM-IV* (Hudson et al., 2007). The authors report the following lifetime prevalence rates for

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AN, BN and BED, respectively: 0.9% among females and 0.3% among males, 1.5% among females and 0.5% among males, and 3.5% among females and 2.0% among males (Hudson et al., 2007). Of note is that BED, a new diagnosis in the *DSM-5* (but one for which criteria appeared in the appendices of *DSM-IV-TR*), is by far the most prevalent of these three eating disorders. Also worth noting is the fact that the statistics for women, specifically for women under age 20, indicate that eating disorders are common among this subset of the population; young women appear to be afflicted at dramatically higher rates than the population at large. Using the *DSM-5* criteria, Stice, Marti, and Rohde (2013) found a lifetime prevalence of 13.1% among this population, concluding that "one in eight young women" (p. 455) will have some form of diagnosable eating disorder.

Not represented in the figures above is the fact that in the past, the most common eating disorder diagnosis has been the *DSM-IV* and the *DSM-IV-TR* category *eating disorder not otherwise specified* (EDNOS; Fairburn & Cooper, 2011; Machado, Gonçalves, & Hoek, 2013). EDNOS cases may represent as many as 60% of eating disorder diagnoses (Fairburn et al., 2007). As Smink, van Hoeken, and Hoek (2012) pointed out, a "major goal" (p. 407) of the revisions reflected among eating disorders in *DSM-5* was to decrease significantly the number of EDNOS or unspecified diagnoses. The addition of BED and the changes to AN and BN (which resulted in generally less stringent criteria) reflect this aim (Smink et al., 2012). Studies concluded that the *DSM-5* criteria will, in fact, reduce the number of EDNOS diagnoses considerably (Allen, Byrne, Oddy, & Crosby, 2013; Fairburn & Cooper, 2011; Machado et al., 2013). The authors in all three studies determined, however, that the number of cases that will not meet the revised *DSM-5* criteria for AN, BN or BED is still sizable (Allen et al., 2013; Fairburn & Cooper, 2011; Machado et al., 2013).

While the prevalence of AN and BN are reasonably well established, the *DSM-5* cites the prevalence of pica as unclear (APA, 2013a). It is predominantly recognized among children, most notably those with intellectual disabilities (Mash & Wolfe, 2013); pregnant women (Geissler, Mwaniki, Thiong'o, & Friis, 1998; Khan et al., 2009); adults with iron deficiency (Moore & Sears, 1994); and institutionalized persons (McAlpine & Singh, 1986). The prevalence of rumination disorder is also inconclusive, but believed to be higher in individuals with intellectual disabilities than the general population (APA, 2013a). Similarly, there are no reported prevalence rates for avoidant/restrictive food intake disorder (APA, 2013a).

Overview of Changes in *DSM-5*

Before the current edition of the *DSM*, feeding and eating disorders were in two main sections of the manual: (1) Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence and (2) Eating Disorders (APA, 2013a). The former no longer appears in the *DSM-5*. With the removal of a separate section describing disorders that were most likely to occur in childhood or adolescence, the *DSM-5* now contains chapters for each diagnostic category, which include both disorders that may first manifest during youth and others that may not surface until adulthood. In line with one objective of the *DSM-5*, the placement of eating and feeding disorders in their own chapter ensures that diagnoses are applicable across the life span (Bryant-Waugh & Kreipe, 2012), and helps bring attention to the development and presentation of symptoms at various points in the life span; this reflects what some refer to as the *age and stage approach* (Bryant-Waugh, 2013). The childhood section that was removed had previously contained several eating disorders (e.g., pica and rumination). The new chapter in the *DSM-5* now contains eight eating disorders (APA, 2013a), including several new disorders, among which are avoidant/restrictive food intake disorder (which replaces, but significantly expands on, feeding disorder of infancy or early childhood) and BED. The diagnoses of *other specified feeding or eating disorders* and *unspecified feeding or eating disorders* are new and replace the diagnosis of EDNOS. The already existing disorders of pica, rumination disorder, AN and BN reflect some minor changes as well. While many feeding and eating disorders share symptoms or behaviors, it is important to note that an individual can receive only

one diagnosis (Dailey et al., 2014). The feeding and eating disorders diagnostic criteria are mutually exclusive, meaning that if a client is diagnosed with one disorder in this chapter, the client cannot be diagnosed with another (with pica as the only exception). The *DSM-5* wants to ensure differentiation of each disorder and help counselors plan treatment that targets the unique features of a disorder (APA, 2013a). See Table 1 for a review of *DSM-IV-TR* and *DSM-5* classification of eating disorders.

Table 1

Past and Current Feeding and Eating Disorder Diagnoses

DSM- IV-TR	*DSM-5*
Pica	Pica
Rumination Disorder	Rumination Disorder
Feeding Disorder of Infancy or Early Childhood	Avoidant/Restrictive Food Intake Disorder
Anorexia Nervosa	Anorexia Nervosa
Bulimia Nervosa	Bulimia Nervosa
	Binge-Eating Disorder
Eating Disorder Not Otherwise Specified (EDNOS)	Other Specified Feeding or Eating Disorder
	Unspecified Feeding or Eating Disorder

Specific Changes to Eating Disorder Diagnoses

Pica and Rumination Disorder

Pica and rumination disorder are two eating disorders that often receive less clinical attention from counselors than other eating disorders. This is probably due to the fact that these disorders are likely to be observed in institutionalized settings, and that treatment may necessitate the expertise of behavioral analysts or therapists highly trained in working with developmental disabilities (Williams & McAdam, 2012). Only the locations of pica and rumination have changed in the *DSM-5*: These disorders now appear in the chapter on feeding and eating disorders. With this change, these diagnoses are now applicable to individuals across the life span. The criteria for these disorders did not change.

Pica is the ingestion of non-nutritive substances (e.g., hair, chalk, paint chips) over at least a one-month period. Availability and the age of the affected individual often determine what substances a person will consume (Hartmann et al., 2012). Some reports have included individuals eating paper, tissues, wood, metal, small rocks, carpet and soap (Matson, Belva, Hattier, & Matson, 2011). The eating of these non-food substances is deemed to be inappropriate to the developmental level of the individual and is not part of a cultural or socially accepted practice (APA, 2013a). Generally, clinicians see this disorder in children with intellectual disabilities (Mash & Wolfe, 2013). However, the fourth criterion of the diagnosis notes that if this condition does occur within the context of a developmental or intellectual disability, it should be sufficiently severe to warrant clinical attention.

Children with pica eat normal foods as well as non-nutritive foods. In most cases, the disorder remits on its own, or will cease with improved environmental conditions or added infant stimulation (Mash & Wolfe, 2013). One common thought is that this disorder presents in children who do not have sufficiently stimulating environments. Hartmann et al. (2012) reported that some clinicians regard pica as a form of self-soothing behavior, employed when one's arousal reaches a certain level. However, for children with intellectual

disabilities, it may be life-threatening (Matson et al., 2011). Ingestion of metal or other items with high toxicity pose a threat to the developing child (Hartmann et al., 2012). There are multiple treatments available for such individuals including punishment, overcorrection, restraint, positive reinforcement, psychopharmacology and time out (Matson et al., 2013). There is some literature that discusses the presence of pica in pregnant women, which may cause lead poisoning or other health issues for the developing fetus (Thihalolipavan, Candalla, & Ehrlich, 2013).

There were no major changes to the diagnosis of rumination disorder in the *DSM-5*. Rumination disorder is repeated regurgitation (e.g., spewing up or spitting up of food) for a period of at least one month (APA, 2013a). This regurgitation of food is not attributable to any related medical or gastrointestinal condition. Thus, the regurgitation is voluntary and distinguished from vomiting or gastroesophageal reflux. Similar to pica, the fourth criterion of this diagnosis notes that if this condition does occur within the context of a developmental or intellectual disability, it is sufficiently severe to warrant clinical attention. Some individuals with rumination disorder appear to engage in the behavior for self-soothing effects, while for others it is habitual and a difficult behavior to reduce (Hartmann et al., 2012). Certainly, this disorder reduces the social functioning of an individual, as it is a socially undesirable behavior.

The *DSM-5* reports that both pica and rumination disorder are generally first observable in infancy, but onset can occur in childhood, adolescence or adulthood. Another commonality of these diagnoses in *DSM-5* is that they both now have a specifier of *in remission*. This is reserved for individuals who may have previously met the criteria of the disorder, but have not "for a sustained period of time" (APA, 2013a, p. 330). Additionally, pica and rumination disorder are concurrently diagnosable. Another commonality of these disorders is that they often occur in secret and are difficult to detect (Hartmann et al., 2012). Individuals are not likely to disclose their engagement in these behaviors. For young children, parental report is critical in assessment.

Avoidant Restrictive Food Intake Disorder

An interesting addition to the *DSM-5* is the diagnosis of avoidant restrictive food intake disorder (ARFID). The essence of this disorder is a disturbance in eating or feeding characterized by inadequate food intake (Bryant-Waugh & Kreipe, 2012). This inadequacy may mean that the individual does not meet necessary energy intake needs for the day (i.e., by consuming too few calories from food), or has an insufficient nutritional diet, or both. This disorder replaces feeding disorder of infancy or early childhood, but also adds significant new criteria. As Kreipe and Palomaki (2012) stated, "Although it has somewhat awkward phrasing, the name captures the key clinical features of non-eating disorder eating disturbances: avoiding (not necessarily 'refusing') foods for a variety of reasons, and restricting intake in the amount and/or range of foods eaten" (p. 428). In the *DSM-IV-TR* (APA, 2000), feeding disorder of infancy or early childhood primarily emphasized the child's persistent failure to eat adequately, with significant failure to gain weight or significant loss of weight over at least one month. The primary symptom was a disturbance in eating or feeding not attributable to an associated medical or gastrointestinal condition, and the disorder was required to have an onset before six years of age. With the addition of ARFID, those criteria remain the same, but there is the additive criterion of significant nutritional deficiency, and dependence on enteral feeding (i.e., tube feeding) or oral nutritional supplements. The diagnosis is more specific in stating that the eating or feeding disturbance may be related to the sensory characteristics of food or a concern about aversive consequences of eating (e.g., nausea). The second criterion (a new addition) also mentions that a lack of available food or an associated, culturally sanctioned practice cannot account for the disturbance. The other criteria remain the same (e.g., ARFID cannot occur during the course of AN or BN; the condition cannot be related to a medical condition). It is, however, likely to co-occur with autism spectrum disorder or other neurodevelopmental disorders. Similar to other disorders in the *DSM-5*, one can apply *in remission* here if the individual previously met the full criteria for the disorder, but now has not met these criteria for a sustained period.

Sometimes the individual with ARFID restricts certain foods, and at other times, there is an inadequate intake of vitamins and minerals. The inadequacy of energy intake may result in a child's poor growth, weight loss or low weight. In their study on picky eating among children, Jacobi, Schmitz, and Agras (2008) pointed out that the longer the duration of the pickiness, the more avoidant the child becomes to trying new foods. However, children with ARFID are more than just picky eaters, as they suffer from failure to meet nutritional and/or energy needs that may result in weight loss. As the criteria imply, some of these individuals must rely on enteral feeding.

The clinical presentation of ARFID is quite variable (Bryant-Waugh & Kreipe, 2012). Over time, there may be evidence that subgroups of the disorder are present, requiring further classification. Bryant-Waugh and Kreipe (2012) describe several presentations that include some of the ARFID symptoms. For example, some children (and some adults) eat only certain-colored foods or foods with a particular texture, thus ingesting only a narrow range of foods. Others may avoid certain foods based on past negative experiences with them, usually gastrointestinal problems. While there is no specific assessment for ARFID, careful clinical interviewing, including parental observations and a medical evaluation, are necessary for diagnosis. Because ARFID and AN share many common symptoms in childhood and young adulthood (e.g., low weight, food avoidance), differential diagnosis may be difficult (APA, 2013a). The *DSM-5* reminds counselors that in AN, the individual has a persistent fear of becoming fat and/or gaining weight, which is not present in ARFID. We refer readers to Bryant-Waugh (2013) for a case study of a child with ARFID, including assessment questions and treatment.

Anorexia Nervosa

The *DSM-5* diagnostic criteria for AN reflect several significant changes from the criteria outlined in *DSM-IV-TR*. There are two particularly noteworthy changes to the first criterion for an AN diagnosis in *DSM-5*. The first of these is that what was described as "refusal to maintain body weight" in the *DSM-IV-TR* (APA, 2000, p. 589) has been reframed as "restriction of energy intake relative to requirements" in the *DSM-5* (APA, 2013a, p. 338). The removal of the word *refusal*, which has negative connotations, results in a more neutrally worded criterion. Moreover, the new phrasing of this criterion in *DSM-5* focuses specifically on the central behavioral component of AN (i.e., restriction of intake), rather than upon the results of this behavior (i.e., body weight).

The second key change to this first criterion is that the specific guideline provided in *DSM-IV-TR* as a definition of a less than "minimally normal" body weight (i.e., below "85% of that expected"; APA, 2000, p. 589) no longer appears in the *DSM-5*. The new criterion instead highlights the essential role of context (e.g., age, sex, developmental status) in determining whether a particular individual is at a "significantly low weight" for his or her own body (APA, 2013a, p. 338). This change is particularly important because, while the *DSM-IV-TR* clarifies that 85% is intended as a guideline, once incorporated into the criteria, it became in many cases a requirement for insurance reimbursement (Hebebrand & Bulik, 2011).

The second criterion for AN previously included only the cognitive symptom of "intense fear of gaining weight or becoming fat" (APA, 2000, p. 589). That same language appears in the *DSM-5*, but the new criterion includes a behavioral component as well. Moreover, because the word *or* is used rather than *and*, the behavioral manifestation of this criterion can actually stand in for other, more overt expressions of the cognitive component. In other words, according to the *DSM-5*, an individual engaging in "persistent behavior that interferes with weight gain" (APA, 2013a, p. 338) can now meet this second criterion even if he or she does not explicitly communicate anxiety around weight gain. This change may have particular relevance in pediatric cases, because some children with AN have not yet developed the cognitive abilities required either to have or to express this intense fear (Bravender et al., 2010; Reierson & Houlihan, 2008; Workgroup for Classification of Eating Disorders in Children and Adolescents, 2007).

The third criterion in the *DSM-5* is very similar to that of the previous edition, aside from one notable distinction. In the new *DSM*, the phrase "persistent lack of recognition" (APA, 2013a, p. 339) replaces "denial" (APA, 2000, p. 589) in describing the anorexic individual's perspective on the risks posed by his or her underweight status. As with the change to criterion one, the result of this rewording is more value-neutral (like *refusal*, the word *denial* has negative connotations). The resulting criterion may also be more accurate, in that the focus is on an inability of the anorexic individual to recognize the inherent dangers of his or her condition, rather than a conscious repudiation of the truth.

Although these small linguistic changes may not seem especially significant, the outcome is a set of criteria that is, on the whole, less stigmatizing. This is important because research indicates that many clinicians have negative biases toward individuals with eating disorders. This may be especially true in the case of those with AN, and the stigma appears to impact the availability of quality treatment for the disorder (Thompson-Brenner, Satir, Franko, & Herzog, 2012).

The fourth criterion for AN, which appears in the previous edition, was removed altogether from the *DSM-5*, so that there are now only three criteria for a diagnosis of AN. This previous criterion, amenorrhea (the cessation of menstruation), applied only to females who had achieved menarche (APA, 2000). By definition, then, this criterion inherently excluded all males, as well as pre-pubertal and post-menopausal females. Also excluded were females taking hormonal contraceptives (APA, 2013b). The removal of amenorrhea therefore results in a more inclusive set of criteria, reflective of the APA's (2013a) stated goal of avoiding "overly narrow" diagnostic categories (p. 12), which in the past have contributed to an excess of EDNOS diagnoses (Fairburn & Cooper, 2011; Machado et al., 2013).

As in the *DSM-IV-TR*, the criteria for AN in the *DSM-5* include specifiers of *restricting* or *binge-eating/purging* types (APA, 2000, 2013a). The language in the new edition is similar to that of the previous edition, but clarifies that the specifier applies to the last 3 months (APA, 2013a), rather than the *DSM-IV-TR*'s more vaguely stated "current episode" (APA, 2000, p. 589). This change is relevant because the empirical evidence indicates that crossover between subtypes is frequent (Eddy et al., 2008). The *DSM-5* reflects this research, and the text in the manual cautions that because such crossover occurs, "subtype description should be used to describe current symptoms rather than longitudinal course" (APA, 2013a, p. 339). It may be worth noting that some in the field have concluded that these diagnostic subtypes of AN are not actually clinically relevant (e.g., Eddy et al., 2008), although clearly the *DSM-5* does not reflect this thinking.

Like other disorders in the *DSM-5*, the diagnostic criteria for AN now include additional specifiers regarding remission status (*partial* or *full*) and severity (APA, 2013a). The remission specifier may be especially useful for clinicians working with individuals with eating disorders, AN in particular. For example, with regard to the weight criterion, an individual who reaches "normal" weight will no longer meet the full criteria for an AN diagnosis, but may still be struggling with other key components of the disorder (e.g., intense fear of weight gain). Such a scenario may be particularly likely with this disorder, especially because a change in weight status can be the result of outside intervention rather than internal motivation (Nicholls, Lynn, & Viner, 2011).

Finally, the *DSM-5* includes a severity specifier that uses the individual's body mass index (BMI). There are three levels of severity: extreme (BMI < 15 kg/m^2), severe (BMI 15–15.99 kg/m^2), moderate (BMI 16–16.99 kg/m^2) and mild (BMI ≥ 17 kg/m^2). As the manual states, the ranges are from the World Health Organization categories for thinness in adults. For children and adolescents, clinicians are encouraged to use the BMI percentiles. These levels of severity help indicate the clinical symptoms, the potential need for supervision and the degree of functional disability (APA, 2013a).

Bulimia Nervosa

The diagnosis of BN remains largely the same in the *DSM-5*, although there are some modifications to the criteria. BN is characterized by repeated, uncontrollable binge-eating episodes (criterion A) accompanied by ongoing compensatory behaviors to avoid weight gain (criterion B). These behaviors to avoid weight gain include "self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise" (APA, 2013a, p. 345). The *DSM-5* brings no changes to these first two criteria from the *DSM-IV-TR*. Also unchanged in the new edition is the fourth criterion, the following key cognitive symptom: "self-evaluation is unduly influenced by body shape and weight" (APA, 2013a, p. 345).

The major change to BN in the *DSM-5* is in criterion C, the frequency of the compensatory behaviors required for diagnosis. In the *DSM-5*, this frequency has been reduced from an average of twice weekly to an average of only once per week. The required duration of these behaviors, however, remains the same in *DSM-5*: three months. Research indicates that individuals who display these behaviors at this new, lower threshold of once per week experience similar levels of pathology and distress (Wilson & Sysko, 2009). This decrease in frequency is likely to result in more diagnoses of BN; as stated, "increased prevalence rates are the result of a general lowering of diagnostic thresholds for eating disorders" (Dailey et al., 2014, p. 180).

A secondary change to the BN criteria is the removal of the specifier regarding *purging* and *nonpurging* types of BN (APA, 2000). In the past, these specifiers described the type of compensatory behavior used by the individual. In the *DSM-5*, the criterion for compensatory behavior includes both types, so no further specifier is necessary. This change reflects the research indicating that many individuals with BN regularly engage in both purging and nonpurging compensatory behaviors, making this specifier insignificant (Ekeroth, Clinton, Norring, & Birgegård, 2013; Vaz, Peñas, Ramos, López-Ibor, & Guisado, 2001).

BN, like the other disorders in the *DSM-5*, now has severity specifiers. For this diagnosis, the assessment of severity depends upon the frequency of inappropriate compensatory behaviors (e.g., the average number of times an individual purges in a given week). Depending on the frequency of compensatory behaviors per week, a case may be categorized as one the following: *mild* (1–3 episodes), *moderate* (4–7 episodes), *severe* (8–13 episodes) or *extreme* (14 or more episodes) (APA, 2013a). Finally, as with other disorders in the *DSM-5*, clinicians can apply the specifiers of *partial* or *full remission* to BN.

Binge-Eating Disorder

The diagnosis of BED is new to the *DSM-5*. First mentioned in the *DSM-IV* (Striegel-Moore & Franko, 2008), the disorder appeared in that edition and the subsequent text revision under EDNOS, with research criteria outlined in the appendices (APA, 2000). With the publication of the *DSM-5*, BED was promoted from "criteria sets . . . for further study" (APA, 2000, p. 759) to being a full-fledged diagnosis. This addition is highly significant because BED is likely to be the most prevalent eating disorder (Striegel-Moore & Franko, 2008).

BED shares the binge-eating criterion of BN (i.e., consuming an objectively large quantity of food in a relatively short time while experiencing a loss of control). The disorder differs from BN, however, in that individuals with BED do not engage in compensatory behaviors (e.g., vomiting or laxative use) after binge eating. An additional distinction is that BED does not include a key cognitive criterion necessary for a diagnosis of BN—the undue influence of weight and shape on self-concept (APA, 2013a).

The second criterion for BED describes behaviors, emotions and cognitions associated with binge eating. The criterion includes five items and specifies that individuals must display a minimum of three to qualify for diagnosis. Examples are eating in the absence of physical hunger, eating unusually quickly and experiencing

feelings of guilt and disgust around eating. Although a diagnosis of BN does require the presence of binge eating, that diagnosis does not include these additional criteria.

As is the case with other eating disorders, the diagnostic criteria for BED in the *DSM-5* reflect reduced requirements for duration and frequency. Whereas the research criteria in the *DSM-IV-TR* specified that bingeing must take place at least two days a week for six months (APA, 2000), the *DSM-5* diagnostic criterion is that binge eating must occur an average of once per week, for a minimum of three months (APA, 2013a). In the *DSM-5*, frequency is measured in times—rather than days—per week (for discussion, see *DSM-IV-TR* Appendix B, APA, 2000). In keeping with the other eating disorders, *DSM-5* includes a severity specifier for BED, with, for example, between one and three episodes per week constituting *mild* BED, and 14 or more episodes per week qualifying as *extreme* (APA, 2013a). The addition of this severity rating is very helpful, as it will allow clinicians to determine the seriousness of the individual's disorder in order to assist in treatment planning. Clinicians should also now specify whether an individual is in partial or full remission from BED.

Obesity

The introduction to the chapter on feeding and eating disorders explicitly addresses the decision not to include obesity as a diagnosis in the *DSM-5*. This statement outlines the reasons that obesity itself does not constitute a mental disorder: "Obesity (excess body fat) results from the long-term excess of energy intake relative to energy expenditure. A range of genetic, physiological, behavioral, and environmental factors that vary across individuals contributes to the development of obesity" (APA, 2013a, p. 329). In other words, obesity is a physical condition caused by a number of contributing factors and is not, therefore, simply the embodiment of a psychological state. The introduction goes on to clarify, however, that there exist complex relationships between obesity and several psychiatric conditions. This section also refers to the connection between obesity and medications used to treat mental disorders (APA, 2013a).

One of the disorders described by the *DSM-5* as having a "robust association" with obesity is BED (APA, 2013a, p. 329). The relationship between obesity and BED is complicated. The manual specifies, on the one hand, that while some obese individuals suffer from BED, the majority do not. Moreover, individuals with BED are not necessarily obese; they may be overweight, or their weight may fall in the normal range (Striegel-Moore & Franko, 2008). On the other hand, obesity is a risk factor for BED (Decaluwé & Braet, 2003), and "the risk of presenting with BED increases with increasing obesity" (Hill, 2007, p. 151). One might assume that binge eating would precede obesity, but the relationship appears to move in the opposite direction (Decaluwé & Braet, 2003). Obesity also is a risk factor for the development of BN (Decaluwé & Braet, 2003; Hill, 2007).

Other Specified Feeding or Eating Disorder and Unspecified Feeding or Eating Disorder

Whereas the *DSM-IV-TR* contained the catchall diagnostic category of EDNOS, this category no longer appears in the *DSM-5*. The EDNOS category previously was reserved for individuals who did not meet the full criteria for an eating disorder (e.g., a woman who meets all criteria for AN except that she has regular menses). It has been reported that this diagnosis was overly used by practitioners (Bryant-Waugh & Kreipe, 2012), so the changes in the *DSM-5* attempt to address this problem. The literature indicates that many individuals who were being treated for an eating disorder received this diagnosis because they did not meet the stringent criteria for AN or BN (e.g., Sysko & Walsh, 2011). As mentioned previously, researchers have reported that EDNOS represented as many as 60% of all eating disorder diagnoses (Fairburn et al., 2007).

In the *DSM-5*, two new diagnostic categories replace EDNOS: other specified feeding or eating disorder and unspecified feeding or eating disorder. Other specified feeding or eating disorder refers to individuals who present symptoms characteristic of a feeding or eating disorder that causes clinically significant impairment, but

does not meet the full criteria for any of the disorders in this section. However, when applying this diagnosis, the clinician is able to specify or state the specific reason that the presentation does not meet the full criteria. Thus, the specific reason should follow the diagnosis. An example of this diagnosis would be BN (of low frequency and/or limited duration). In this example, the individual meets all of the criteria of BN except that the inappropriate compensatory behavior and binge eating occur at a frequency less than once a week and/or for less than 3 months.

This diagnosis presents a contrast with another new diagnosis, unspecified feeding or eating disorder. In using this designation, the clinician is unable to provide the specific reason why the clinical presentation does not meet full criteria. This may be because of insufficient information from the client, such as may occur when a client obtains treatment in an emergency setting or a clinician fails to gather enough information during intake. In these cases, the client displays symptoms of an eating or feeding disorder that is causing clinically significant impairment, but does not meet the full criteria for any disorder.

Implications for Counselors

Given the prevalence of some eating disorders, as well as their presence across the life span, counselors will likely encounter individuals suffering from a diagnosable eating disorder at some point in their career. In fact, research suggests that *DSM-5* criteria will result in a rise in the prevalence of diagnosable eating disorders (Allen et al., 2013). This prediction underscores the importance of those in the counseling profession becoming well-informed regarding these revised criteria. New, broader criteria, when implemented by well-informed professionals, will likely increase the chances that a greater portion of the individuals suffering from these disorders will receive the help they need.

Feeding and eating disorders appear to exist on a continuum, with some related behaviors frequently occurring in the population at large. The skilled counselor will be able to differentiate between behaviors that would not be considered pathological (e.g., overeating or typical "dieting"), or are developmentally appropriate (e.g., picky eating), and those that are indicative of greater dysfunction (e.g., binge eating, dramatically restricting calories). Counselors should be aware, however, that clients with eating disorders may not be forthcoming about their symptoms, hide their behaviors and display resistance to seeking help (Abbate-Daga, Amianto, Delsedime, De-Bacco, & Fassino, 2013). Also, many individuals who are at risk for developing eating disorders or who have them may never seek help (Dailey et al., 2014). In addition, full recovery from eating disorders is the outcome in only about 50% of cases, while 20% of individuals make no improvement (Schlozman, 2002). Thus, many individuals have a lifelong battle with eating disorders and relapse is common. It is critical, therefore, that counselors screen all clients for potential eating disorders. Careful assessment of the client's underlying thoughts, symptom presentation and impairment will help counselors make a correct diagnosis.

Eating disorders can be damaging to one's physical well-being, emotional health and interpersonal relationships (Dailey et al., 2014). These factors, coupled with the possible medical consequences and potential fatality of some eating disorders, highlight the need for counselors who work with these clients to have specialized training. If a counselor does not have the appropriate background in eating disorders, it is vital that he or she refer the client to an eating disorders specialist. Moreover, individuals with eating disorders must consult a physician for a comprehensive physical assessment and intervention (Piran, 2013). Given the complexity of the symptom presentation, treatment is likely to involve a multidisciplinary team approach for treatment of eating disorders (Dailey et al., 2014) and counselors would be wise to familiarize themselves with treatment resources in their community.

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References

Abbate-Daga, G., Amianto, F., Delsedime, N., De-Bacco, C., & Fassino, S. (2013). Resistance to treatment and change in anorexia nervosa: A clinical overview. *BMC Psychiatry*, *13*, 294–311. doi:10.1186/1471-244X-13-294

Allen, K. L., Byrne, S. M., Oddy, W. H., & Crosby, R. D. (2013). DSM-IV-TR and DSM-5 eating disorders in adolescents: Prevalence, stability and psychosocial correlates in a population-based sample of male and female adolescents. *Journal of Abnormal Psychology*, *122*, 720–732. doi:10.1037/a0034004

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2013b). *Highlights of changes from DSM-IV-TR to DSM-5*. Retrieved from http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf

Bravender, T., Bryant-Waugh, R., Herzog, D., Katzman, D., Kriepe, R. D., Lask, B., . . . Zucker, N. (2010). Classification of eating disturbances in children and adolescents: Proposed changes for the DSM-V. *European Eating Disorders Review*, *18*, 79–89. doi:10.1002/erv.994

Bryant-Waugh, R. (2013). Avoidant restrictive food intake disorder: An illustrative case example. *International Journal of Eating Disorders*, *46*, 420–423. doi:10.1002/eat.22093

Bryant-Waugh, R., & Kreipe, R. E. (2012). Avoidant/restrictive food intake disorder in *DSM-5*. *Psychiatric Annals*, *42*, 402–405. doi:10.3928/00485713-20121105-04

Dailey, S. F., Gill, C. S., Karl, S. L., & Barrio Minton, C. A. (2014). *DSM-5 learning companion for counselors*. Alexandria, VA: American Counseling Association.

Decaluwé, V., & Braet, C. (2003). Prevalence of binge-eating disorder in obese children and adolescents seeking weight-loss treatment. *International Journal of Obesity*, *27*, 404–409. doi:10.1038/sj.ijo.0802233

Eddy, K. T., Dorer, D. J., Franko, D. L., Tahilani, K., Thompson-Brenner, H., & Herzog, D. B. (2008). Diagnostic crossover in anorexia nervosa and bulimia nervosa: Implications for DSM-V. *The American Journal of Psychiatry*, *165*, 245–250. doi:10.1176/appi.ajp.2007.07060951

Ekeroth, K., Clinton, D., Norring, C., & Birgegård, A. (2013). Clinical characteristics and distinctiveness of DSM-5 eating disorder diagnoses: Findings from a large naturalistic clinical database. *Journal of Eating Disorders*, *1*, 31–41. doi:10.1186/2050-2974-1-31

Fairburn, C. G., & Cooper, Z. (2011). Eating disorders, DSM-5 and clinical reality. *The British Journal of Psychiatry*, *198*, 8–10. doi:10.1192/bjp.bp.110.083881

Fairburn, C. G., Cooper, Z., Bohn, K., O'Connor, M. E., Doll, H. A., & Palmer, R. L. (2007). The severity and status of eating disorders NOS: Implications for DSM-V. *Behaviour Research and Therapy*, *45*, 1705–1715. doi:10.1016/j.brat.2007.01.010

Geissler, P. W., Mwaniki, D., Thiong'o, F., & Friis, H. (1998). Geophagy as a risk factor for geohelminth infections: A longitudinal study of Kenyan primary schoolchildren. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, *92*, 7–11. doi:10.1016/S0035-9203(98)90934-8

Hartmann, A. S., Becker, A. E., Hampton, C., & Bryant-Waugh, R. (2012). Pica and rumination disorder in *DSM-5*. *Psychiatric Annals*, *42*, 426–430. doi:10.3928/00485713-20121105-09

Hebebrand, J., & Bulik, C. M. (2011). Critical appraisal of the provisional DSM-5 criteria for anorexia nervosa and an alternative proposal. *International Journal of Eating Disorders*, *44*, 665–678. doi:10.1002/eat.20875

Hill, A. J. (2007). Obesity and eating disorders. *Obesity Reviews*, *8*, 151–155. doi:10.1111/j.1467-789X.2007.00335.x

Hudson, J. I., Hiripi, E., Pope, H. G., Jr., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the

national comorbidity survey replication. *Biological Psychiatry*, *61*, 348–358. doi:10.1016/j.biopsych.2006.03.040
Jacobi, C., Schmitz, G., & Agras, W. S. (2008). Is picky eating an eating disorder? *International Journal of Eating Disorders*, *41*, 626–634. doi:10.1002/eat.20545
Khan, N. Z., Ferdous, S., Islam, R., Sultana, A., Durkin, M., & McConachie, H. (2009). Behaviour problems in young children in rural Bangladesh. *Journal of Tropical Pediatrics*, *55*, 177–182. doi:10.1093/tropej/fmn108
Kreipe, R. E., & Palomaki, A. (2012). Beyond picky eating: Avoidant/restrictive food intake disorder. *Current Psychiatry Report*, *14*, 421–431. doi:10.1007/s11920-012-0293-8
Machado, P. P. P., Gonçalves, S., & Hoek, H. W. (2013). DSM-5 reduces the proportion of EDNOS cases: Evidence from community samples. *International Journal of Eating Disorders*, *46*, 60–65. doi:10.1002/eat.22040
Mash, E. J., & Wolfe, D. A. (2013). *Abnormal child psychology* (5th ed.). Belmont, CA: Wadsworth.
Matson, J. L., Belva, B., Hattier, M. A., & Matson, M. L. (2011). Pica in persons with developmental disabilities: Characteristics, diagnosis, and assessment. *Research in Autism Spectrum Disorders*, *5*, 1459–1464. doi:10.1016/j.rasd.2011.02.006
McAlpine, C., & Singh, N. N. (1986). Pica in institutionalized mentally retarded persons. *Journal of Mental Deficiency Research*, *30*, 171–178. doi:10.1111/j.1365-2788.1986.tb01309.x
Moore, D. F., Jr., & Sears, D. A. (1994). Pica, iron deficiency, and the medical history. *The American Journal of Medicine*, *97*, 390–393. doi:10.1016/0002-9343(94)90309-3
Nicholls, D. E., Lynn, R., & Viner, R. M. (2011). Childhood eating disorders: British national surveillance study. *The British Journal of Psychiatry*, *198*, 295–301. doi:10.1192/bjp.bp.110.081356
Piran, N. (2013). Prevention of eating disorders in children: The role of the counselor. In L. H. Choate (Ed.), *Eating disorders and obesity: A counselor's guide to prevention and treatment* (pp. 201–219). Alexandria, VA: American Counseling Association.
Reierson, A. R., & Houlihan, D. D. (2008). Childhood onset of anorexia nervosa. *Gundersen Lutheran Medical Journal*, *5*, 9–12.
Schlozman, S. (2002, March). The shrink in the classroom: Feast or famine. *Educational Leadership*, *59*(6), 86–87. Retrieved from http://www.ascd.org/publications/educational-leadership/mar02/vol59/num06/Feast-or-Famine.aspx
Smink, F. R. E., van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports*, *14*, 406–414. doi:10.1007/s11920-012-0282-y
Stice, E., Marti, C. N., & Rohde, P. (2013). Prevalence, incidence, impairment, and course of the proposed DSM-5 eating disorder diagnoses in an 8-year prospective community study of young women. *Journal of Abnormal Psychology*, *122*, 445–447. doi:10.1037/a0030679
Striegel-Moore, R. H., & Franko, D. L. (2008). Should binge eating disorder be included in DSM-V? A critical review of the state of the evidence. *Annual Review of Clinical Psychology*, *4*, 305–324. doi:10.1146/annurev.clinpsy.4.022007.141149
Sysko, R., & Walsh, B. T. (2011). Does the broad categories for the diagnosis of eating disorders (BCD-ED) scheme reduce the frequency of eating disorder not otherwise specified? *International Journal of Eating Disorders*, *44*, 625–629. doi:10.1002/eat.20860
Thihalolipavan, S., Candalla, B. M., & Ehrlich, J. (2013). Examining pica in NYC pregnant women with elevated blood lead levels. *Maternal and Child Health Journal*, *17*, 49–55. doi:10.1007/s10995-012-0947-5
Thompson-Brenner, H., Satir, D. A., Franko, D. L., & Herzog, D. B. (2012). Clinician reactions to patients with eating disorders: A review of the literature. *Psychiatric Services*, *63*, 73–78. doi:10.1176/appi.ps.201100050
Vaz, F. J., Peñas, E. M., Ramos, M. I., López-Ibor, J. J., & Guisado, J. A. (2001). Subtype criteria for bulimia nervosa: Short- versus long-term compensatory behaviors. *Eating Disorders*, *9*, 301–311. doi:10.1080/106402601753454877
Williams, D. E., & McAdam, D. (2012). Assessment, behavioral treatment, and prevention of pica: Clinical guidelines and recommendations for practitioners. *Research in Developmental Disabilities*, *33*, 2050–2057. doi:10.1016/j.ridd.2012.04.001
Wilson, G. T., & Sysko, R. (2009). Frequency of binge eating episodes in bulimia nervosa and binge eating disorder: Diagnostic considerations. *International Journal of Eating Disorders*, *42*, 603–610. doi:10.1002/eat.20726
Workgroup for Classification of Eating Disorders in Children and Adolescents. (2007). Classification of child and adolescent eating disturbances. *International Journal of Eating Disorders*, *40*(S3), S117–S122. doi:10.1002/eat.20458

Trauma Redefined in the *DSM-5*: Rationale and Implications for Counseling Practice

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Trauma survivors are a unique population of clients that represent nearly 80% of clients at mental health clinics and require specialized knowledge on behalf of counselors. Researchers and trauma theorists agree that, with the exception of dissociative identity disorder, no other diagnostic condition in the history of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) has created more controversy with respect to the boundaries of the condition, diagnostic criteria, central assumptions and clinical utility than post-traumatic stress disorder. However, this mutable conceptualization of trauma and its aftermath have considerable implications for counseling practice. With the recently released fifth edition of the *DSM* (*DSM-5*), the definition of trauma and the diagnostic criteria for post-traumatic stress disorder have changed considerably. This article highlights the changing conceptualization of trauma and how the *DSM-5* definition impacts effective practices for assessing, conceptualizing and treating traumatized clients.

Keywords: **trauma, post-traumatic stress disorder, PTSD, *DSM-5*, diagnostic, clinical utility**

Nearly 80% of clients seen in community mental health clinics have experienced at least one incident of trauma during their lifetime, representing roughly five out of every six clients (Breslau & Kessler, 2001). Over the past 15 years, between increases in school and community violence in the United States and unrelenting wars overseas, overt exposure to traumatic events has become an epidemic. Such events affect individuals across the life span and precipitate numerous diagnoses within the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), most notably post-traumatic stress disorder (PTSD; Breslau & Kessler, 2001).

Survivors of trauma are a unique population of clients who require specialized knowledge and multifaceted considerations on behalf of counselors (Briere & Scott, 2006). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) reiterates across both master's and doctoral training levels the importance of understanding the implications of trauma theory, research and practice in counselor preparation and ultimately practice. CACREP (2009) standards incorporate trauma training within all eight core curricular areas of demonstrated knowledge and within each core counseling track. Section II, *Professional Identity*, says that counselors should understand the "effects of … trauma-causing events on persons of all ages" (CACREP, 2009, p. 10). However, even with the notable rates of trauma exposure, the deleterious outcomes faced by survivors and the call for counselor training in this area, counselors report feeling unprepared to work with survivors (Parker & Henfield, 2012). Over 60% of practicing therapists reported wanting additional support and education in their trauma work (Cook, Dinnen, Rehman, Bufka, & Courtois, 2011).

Trauma theorists agree that, with the exception of dissociative identity disorder, no other diagnostic condition in the history of the *DSM* has created more controversy about boundaries of the condition, symptomatological profile, central assumptions, clinical utility and prevalence than PTSD (Brewin, Lanius, Novac, Schnyder, &

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Galea, 2009). Changing definitions and the rationale for such shifts have significant implications for counselors. The fifth edition of the *DSM* (*DSM-5*), released in May 2013 (American Psychiatric Association [APA], 2013a), contains substantial changes, including the reorganization of "Trauma- and Stressor-Related Disorders" (TSRDs) into a new category and chapter distinct from "Anxiety Disorders," the restructuring of factors, the modification of symptoms and specifiers, and the addition of a new subtype of PTSD in children.

The highly debated and variable definition of trauma and the diagnostic criteria for psychological responses to traumatic events may contribute to low counselor efficacy in trauma practice. Without a clear understanding of the latest views and requirements for trauma diagnosis using *DSM-5*, counselors may feel tentative about assessing for trauma and selecting efficacious interventions. This manuscript explores the changing definitions of trauma over time, implications of such changes on counseling practice and areas of needed growth and research. While this article's core focus is on PTSD, we also briefly describe other TSRDs. By outlining *DSM-5* changes, reviewing recent research substantiating such modifications and providing practical suggestions for practitioners, we hope to mitigate confusion and enhance efficacy in counselors working with trauma clients during this crucial diagnostic transition.

History of Trauma

Derived from the Greek word for "wound," tales of trauma and the its profound consequences thereof date back to writings in antiquity. Only in the late 19th century did Pierre Janet and Sigmund Freud provide the first writings on the characterizations and clinical implications of traumatic events. In the mid-1890s, both practitioners developed similar theories of the etiology of hysteria, namely experiences of psychological trauma, particularly sexual trauma (Herman, 1992a). The theories presented in Freud's *The Aetiology of Hysteria* (1962), however, were met with vehement contention, and such censuring stifled potential ramifications of his discoveries. Consequently, contemporary theories and definitions of trauma became largely fashioned from studies of male soldiers' reactions to the horrors of war. Investigations of traumatic stress and apposite interventions for survivors emerged following World War I, purportedly as a means of rehabilitating soldiers for redeployment (van der Kolk, 2007). This attention waned during times of peace, but took command of the mental health research and literature during the Vietnam War. Concurrently, marked attention again became drawn to the consequences of sexual and domestic violence against women and children owing to the Women's Movement (Herman, 1992a).

The examination of traumatic responses on both fronts (i.e., combat and interpersonal violence) led to the inclusion of a distinct PTSD diagnosis in the third edition of the *DSM* (*DSM-III*; APA, 1980). Previous iterations of the *DSM* recognized reactions to stressful experiences as a "transient situational disturbance," suggesting that without an underlying psychological condition, the individual's psychological experiences would wane as the stressor subsided (Yehuda & Bierer, 2009). However, the *DSM-III* classified trauma as an event existing "outside the range of usual human experience" (APA, 1980, p. 236) and provided legitimization for the potential pervasive and deleterious effects of exposure. As research continues, however, both the definitions of what constitutes a traumatic experience and what characterizes the symptoms of PTSD have rapidly transformed.

The publications of the *DSM-IV* and *DSM-IV-TR* brought a considerably more inclusive definition of trauma (APA, 1994, 2000).Varied events as a car accident, a natural disaster, learning about a death of a loved one, and even a particularly difficult divorce were considered variations of traumatic experience. This expanded definition engendered a 59% increase in trauma diagnoses (Breslau & Kessler, 2001). Modern trauma theory conceptualizes trauma and traumatic responses as occurring along a continuum (Breslau & Kessler, 2001), with researchers elucidating the importance of differentiating between traumatic experiences when investigating the

etiology, physiological responses, course and efficacious therapeutic interventions for the range of potential traumatic responses (Breslau & Kessler, 2001; Kelley, Weathers, McDevitt-Murphy, Eakin, & Flood, 2009). The unique consequences of these diverse populations may be obscured if survivors of disparate populations are combined in research or excluded from trauma definitions altogether.

Primary Challenges to the *DSM-IV-TR*

The 13 years between the *DSM-IV-TR* (2000) and the *DSM-5* (2013a) engendered considerable debate regarding how trauma was defined and the core criteria of PTSD. In the *DSM-IV-TR*, the presence of at least six symptoms (out of 17) distributed among three core symptom clusters served as a basis for diagnosing PTSD. This three-factor model stipulated that following a traumatic event, which induced fear, helplessness or horror, a survivor must experience at least one symptom of persistent re-experiencing (criterion B), three symptoms of avoidance or emotional numbing (criterion C), and two indicators of increased arousal (criterion D), all of which must persist for at least 1 month. Further, a clinician could specify whether the condition was *acute*, *chronic* and/or *with delayed onset*. An examination of the challenges surrounding this diagnosis follows.

Is Trauma an Anxiety Disorder?

PTSD was historically characterized as an anxiety disorder within the *DSM*. Authors supporting this view reference the pronounced fear and classical conditioning believed central among survivor experiences and treatment approaches that aim to extinguish such fear-based responses (i.e., exposure therapies; Zoellner, Rothbaum, & Feeny, 2011). Zoellner et al. (2011) branded PTSD a "quintessential anxiety disorder" (p. 853), arguing that the co-occurrence of PTSD with other anxiety disorders suggests common core constructs. These authors warned that reclassifying PTSD would suggest incorrectly to clinicians and researchers that "fear and anxiety are not critical in understanding PTSD" (p. 855). However, other researchers promoted making trauma-related disorders a new diagnostic category, suggesting that the traumatic event and not the symptoms demarcate such disorders (Nemeroff et al., 2013). Nemeroff et al. (2013) suggested that using the traumatic event as the foundation for the diagnosis respects the intensely heterogeneous nature and symptomatic presentation of the disorder.

Precipitating Events and Subjective Response

Also termed the *stressor criterion*, PTSD criterion A stipulated two requirements. An individual must first experience a traumatic episode (A1), defined as:

> A direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about an unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate (APA, 2000, p. 463).

The second prerequisite (A2) required that the survivor must have experienced "intense fear, helplessness, or horror" (p. 467) following the event. Clinicians and researchers have criticized both requirements (Breslau & Kessler, 2001; Friedman, Resick, Bryant, & Brewin, 2011).

The debate over what constitutes a traumatic event emerged with the first inclusion of the diagnosis into the *DSM-III*, and has persisted. Some researchers argued that the *DSM-IV*'s broad definition of trauma led to "bracket creep" (McNally, 2009, p. 598) and overdiagnosis of PTSD resulting from less threatening events. McNally (2009) questioned the ramifications of having equivalent diagnoses for a traumatized individual

who watched the World Trade Center collapse from thousands of miles away and a survivor who escaped the building directly. Some postulated that weakening the A1 criteria had detrimental outcomes in client care and in forensic and disability settings and supported a narrower definition of trauma (Rosen & Lilienfeld, 2008). Others starkly disagreed, suggesting that what may be traumatic for one individual may not be for another, and that an attempt to include all possible traumatic events within the context of a diagnosis was futile (Brewin et al., 2009). Numerous researchers and clinicians have remarked that for no other diagnosis in the *DSM* is a specific precursory event stipulated, and they have argued for the removal of the A1 event altogether (Brewin et al., 2009), questioning the compulsory relationship between a traumatic event and PTSD (i.e., other disorders may result from such an event) and asserting that minor events, repeated over time, can likewise lead to PTSD.

More prominent was dispute over the latter stressor requirement (A2). Friedman et al. (2011) emphasized that the presence of a subjective response did not predict that an individual who would go on to develop PTSD. Although these subjective responses are characteristic trauma reactions, limiting the range of psychological responses may discount subpopulations, most notably survivors of sexual and partner violence, military and first responders (Friedman et al., 2011). The predominant post-traumatic reactions of interpersonal violence survivors include anger, guilt and shame; the military and first responders often report not having an immediate emotional reaction to traumatic exposure as a result of their training. In a sample of adult sexual assault survivors, over 75% endorsed shame as a leading psychological response (Vidal & Petrak, 2007). Over 20% of survivors were misdiagnosed due to not meeting the A2 criteria (Creamer, McFarlane, & Burgess, 2005).

Three-factor Model: The Avoidance and Numbing Debate

The third criterion for a PTSD diagnosis in *DSM-IV-TR* included experiencing at least three symptoms related to *either* behavioral avoidance *or* affective numbing (APA, 2000). Having a double-barreled criterion engendered considerable disagreement in trauma research and clinical practice. Although these two constructs were initially considered synonymous, with emotional numbing serving as a volitional form of emotional avoidance, research has elucidated differences in their bases, functions and neurophysiological underpinnings (Asmundson, Stapleton, & Taylor, 2004). Foa, Riggs, and Gershuny (1995) further determined that emotional numbing, over and above avoidance or another symptomatic feature of PTSD, best distinguishes PTSD from other diagnostic categories. Conceptually, authors (Foa, Zinbarg, & Rothbaum, 1992; Ullman & Long, 2008) frequently distinguished avoidance and numbing by examining the intentionality behind the event: whereas avoidance represents conscious attempts to escape trauma-related stimuli or responses, numbing is an unconscious and automatic physiological response to trauma exposure. Confirmatory factor analyses substantiated such claims and repeatedly demarcated a four-factor rather than a three-factor model of PTSD that differentiates avoidance and numbing (Friedman et al., 2011).

The integrated conceptualization of numbing and avoidance had marked significance on clinical practice. It was often difficult to confirm three of the seven conditions (Schützwohl & Maercker, 1999), leading to subthreshold diagnoses or underdiagnosis. Further, the severity of numbing precipitated a category of trauma survivors marked by the most chronic and pervasive disturbances following trauma and most pronounced disruptions in daily life (Breslau, Reboussin, Anthony, & Storr, 2005). In addition, Asmundson et al. (2004) determined that symptoms of avoidance and numbing are differentially influenced by treatment approaches, reinforcing the notion that avoidance and numbing should be considered and clinically addressed as distinct symptomatic concerns. Further, using the *DSM-IV*, a clinician treating an unconscious response (i.e., numbing) as an intentional action (i.e., avoidance) could unintentionally lead to treatment that was ineffective, blaming, disempowering or even re-traumatizing to clients.

Subthreshold Diagnoses

Several of the aforementioned considerations denote concern around subthreshold or subsyndromal survivors, namely individuals whose trauma did not match the A1 or A2 events or whose symptoms did not fulfill the restrictive criterion C. These survivors, potentially facing grossly impaired functioning, did not fulfill PTSD criteria and thus may have been prohibited from receiving any services, appropriate services or related validation of their experiences (Cukor, Wyka, Jayasinghe, & Difede, 2010; Schützwohl & Maercker, 1999). Problems with subthreshold diagnoses and misdiagnoses under the *DSM-IV* guidelines were particularly notable among children (Pynoos et al., 2009; Scheeringa, Zeanah, & Cohen, 2011). Using *DSM-IV* criteria, over 30% of children with pervasive symptoms and severe functional impairment did not meet criteria (Scheeringa, Myers, Putnam, & Zeanah, 2012). Although notes regarding symptom presentation in children were presented, the *DSM-IV* did not identify a separate diagnosis for preschool post-traumatic reactions. Researchers argued that the *DSM-IV* criteria were not attentive to developmental considerations, owing largely to the linguistic and introspective differences of young children, and provided unrepresentative criteria for this population (Pynoos et al., 2009; Scheeringa et al., 2011). Consequently, researchers highlighted the need for child-specific PTSD criteria. Underdiagnosis in children and adults is particularly troubling given that these populations of survivors have long been misdiagnosed and stigmatized by the *DSM* (Fish, 2004; Rojas & Lee, 2004). Drawing on both behavioral and neurological research, these challenges to the *DSM-IV* PTSD diagnosis touched at the core of trauma theory and resulted in many shifting perspectives in the fifth edition. Given the historical complications in trauma theory and recent reformulations of trauma, it is important that counselors receive guidance on trauma-informed practice using the *DSM-5* (APA, 2013a).

Shifting Perspectives and New *DSM-5* Diagnostic Criteria

In the *DSM-5*, PTSD now serves as the cornerstone of a new category of diagnoses, TSRD. Within the new category, the definition of trauma is more explicit, and the symptomatic profile was expanded from a three- to four-factor structure. Subjective responses following a traumatic event are no longer required, and a separate preschool diagnosis for children 6 years old and younger is now available. The modifications to the PTSD diagnosis in the *DSM-5* are delineated in Table 1.

Exemption from Anxiety Disorders

The foremost change in the *DSM-5* diagnosis of PTSD is its assignment to an innovative diagnostic category, TSRDs. Throughout the review period, members of the Trauma and Stressor-Related and Dissociative Disorders (TSRDD) Sub-Work Group of the *DSM-5* (Friedman, 2013) determined that PTSD did not "fit neatly into the anxiety disorder niche to which it had been assigned since *DSM-III*" (p. 549). This redefining of PTSD marks a significant shift from its former conceptualization and highlights the central importance of the predisposing stressor. Exposure to a traumatic or aversive event is now recognized as a vital cause of an entire class of conditions affecting mental well-being. Before the *DSM-5*, trauma exposure was an accepted catalyst of Acute Stress Disorder and PTSD, yet the explicit influence of such aversive events on numerous other disorders went largely unacknowledged.

Restructuring the Stressor Criterion

Emphasis on the precipitating traumatic event called for reconsideration of the definition of trauma. Despite the argument by Brewin et al. (2009) that what is or is not considered a traumatic event should be defined by the individual rather than a committee, the *DSM-5* retained criterion A1, with modifications to the breadth of the definition. Trauma is now defined as exposure to actual or threatened death, serious injury or sexual violence in one or more of four ways: (a) directly experiencing the event; (b) witnessing, in person, the event occurring to others; (c) learning that such an event happened to a close family member or friend; and (d) experiencing

repeated or extreme exposure to aversive details of such events, such as with first responders. Actual or threatened death must have occurred in a violent or accidental manner; and experiencing cannot include exposure through electronic media, television, movies or pictures, unless it is work-related.

Table 1

Key Modifications to PTSD in DSM-5

PTSD Modifications	
Location	New category: "Trauma- and Stressor-Related Disorders" No longer a subcategory of "Anxiety Disorders"
Criteria	
A. Exposure	Included sexual violence as a traumatic event Exposure refined to include: • Learning the event(s) occurred to close family or friend[a], • Repeated or extreme exposure to details of the event(s)[b], i.e., vicarious trauma. Removed A2, subjective response (i.e., fear, helplessness, horror)
B. Intrusion (1 of 5)	No major changes
C. Avoidance (1 of 2)	New separate criterion (factor) for avoidance symptoms No major changes to symptoms
D. Negative Alterations in Mood/cognition (2 of 7)	New criterion (factor) for numbing symptoms Two new symptoms: • Persistent negative emotional states • Persistent blame
E. Arousal and Reactivity (2 of 6)	One new symptom: • Reckless or self-destructive behavior
F. Duration	No change: Still 1 month since stressor
G. Significance	No change
H. Not substance or medical	Added criterion
Specifiers	Two types available: • With dissociative sx, i.e., depersonalization or derealization • With delayed expression of 6 or more months
Subtype	For children 6 years or younger (Preschool subtype) Separate criteria

Note. sx = symptoms. Adapted from *DSM-5* (APA, 2013a, p. 272).

[a]Actual or threatened death must have been violent or accidental.

[b]Such exposure through media, television, movies or pictures does not qualify unless for work.

Several changes in the *DSM-5* definition stand out immediately, such as the inclusion of sexual violence within the core premise of trauma. Experiencing sexual violence may precipitate PTSD, as can witnessing it, learning about it and experiencing repeated exposure to stories of such acts. Furthermore, loss of a loved one to natural causes is no longer considered a causal factor. For example, now a client whose partner unexpectedly died of a heart attack no longer fits PTSD criteria. Lastly, a new subset of possible exposure has been established, namely vicarious trauma. This is the first time that *DSM* criteria have included deleterious effects of repeatedly witnessing or hearing stories regarding the aftermath of trauma. This inclusion may not be surprising to trauma counselors, as nearly 15–20 % develop PTSD symptoms from hearing and sharing in the stories of survivors; this inclusion may help to legitimize the gravity of counselors' reactions (Arvay & Uhlemann, 1996; Meldrum, King, & Spooner, 2002). The inclusion also may serve to de-stigmatize the reactions of first responders and reinforce the need for wellness training and post-exposure care (Royle, Keenan, & Farrell, 2009). However, the *DSM-5* clearly states that vicarious trauma cannot be the result of repeated exposure via electronic or print media. This precludes, for example, McNally's (2009) case example of an individual with trauma symptoms who repeatedly witnessed the attacks on the World Trade Center by way of television monitors.

Removal of Subjective Response

Along with changes to the definition of trauma, the *DSM-5* now excludes the A2 subjective response. The PTSD diagnosis now represents survivors who experience reactions other than fear, helplessness or horror, or who exhibit no pronounced emotional response. For example, a client who witnessed a fatal car accident and predominantly feels pervasive guilt for not offering support could be diagnosable. This change has great significance for numerous populations and may lead to more survivors gaining access to efficacious mental health care.

A Four-Factor Approach

In accordance with evidence supporting a four-factor model of PTSD, the APA (2013a) split the previous criterion C into two distinct categories within the *DSM-5*: (a) avoidance and (b) negative reactivity and related numbing. The new criterion C (i.e., persistent avoidance) requires only one of the two original avoidance symptoms. The new criterion D in *DSM-5*, "negative alterations in cognitions and mood" (p. 271, APA, 2013a), underscores the notion that trauma leads to unconscious numbing of positive emotions and increased negative affect overall (Frewen et al., 2010). Persistent negative emotionality and persistent blame are additions to the original symptom profile, the latter of which predicts PTSD severity and chronicity (Moser, Hajcak, Simons, & Foa, 2007). Two of seven symptoms must be endorsed in the new criterion D.

Criterion B (i.e., presence of intrusive symptoms) remains unchanged from the *DSM-IV*, and requires only one of five symptoms. The new criterion E, persistent alterations in arousal, reflects the previous criterion D and includes one additional symptom, reckless or self-destructive behaviors. Self-destructive behaviors comprise anything from hazardous driving to suicidal behavior (Friedman, 2013). Two of the now six symptoms of altered arousal are required. Despite refinements to criteria, considerable overlap remains across and within PTSD symptoms, such as between intrusion and the dissociative-depersonalization specifier.

Dissociative Specifier

In addition to delayed expression, the *DSM-5* includes specifiers for dissociative symptoms in PTSD, with either depersonalization or derealization constituting the primary presentation. Dissociation often predicts significantly greater severity, chronicity and impairment in survivors, as well as decreased responsiveness to common treatment approaches (Lanius, Brand, Vermetten, Frewen, & Spiegel, 2012). The inclusion of this subtype acknowledges differences in neurological and physiological functioning among this population (Felmingham et al., 2008) and relevant needs and clinical considerations (Lanius et al., 2012).

Post-traumatic Stress Disorder in Children

In recognizing the gross oversights in previous iterations of the *DSM* regarding developmental considerations in PTSD, the *DSM-5* explicitly provides a preschool subtype for children 6 years and younger. This new diagnosis honors the unique trauma experiences and responses of children, with symptoms that are behaviorally based and thus not reliant upon the cognitive or linguistic complexity absent in young survivors. For example, symptoms include restless sleep, temper tantrums or decreased participation in play. Children may express symptoms through behavior or play reenactment, which may or may not appear related to the traumatic event. The preschool subtype retains the three-factor model that combines avoidance and negative alterations of mood and cognition. To circumvent concerns related to children not meeting criterion C requirements, only one of six symptoms is necessary. These changes have pronounced implications for counseling adult and child survivors of trauma.

Implications for Counseling Practice

Understanding these changes and the rationale behind them is essential to thorough client conceptualization and efficacious counseling. Otherwise, counselors may feel tentative about key areas of care, such as assessing for trauma exposure, making accurate diagnoses, selecting efficacious interventions and filing reimbursement claims. A consideration of specific ways the new that the *DSM-5* PTSD diagnosis impacts counselors, clients and clinical practice follows.

Multifarious Symptom Structure and Trauma Prevalence

The expanded PTSD symptom set in the *DSM-5* set leads to extensive variations in possible trauma responses. The increase in symptoms from 17 in the *DSM-IV-TR* to 20 in the *DSM-5* now yields over 600,000 possible symptom combinations (Galatzer-Levy & Bryant, 2013). Consider this number in comparison to the potential 70,000 combinations possible in the *DSM-IV-TR* (2000), a number already criticized for its expansiveness, and the meager 256 possible for depression (Zoellner et al., 2011). This marked increase in symptom patterns calls into question prevalence rates for trauma under the new *DSM*. A recent study established similar prevalence rates using *DSM-5* and *DSM-IV-TR* criteria, 39.8% and 37.5%, respectively, and an overall 87% consistency between the two versions (Carmassi et al., 2013). Carmassi et al. (2013) determined that the discrepancy was due primarily to individuals not fulfilling criterion C within the *DSM-IV-TR*. This finding illustrates the impact of modifications related to the bifurcation of avoidance and numbing. Kilpatrick et al. (2013), however, found marginally decreased prevalence with the *DSM-5*, citing constraints on the A1 definition of trauma. However, both studies found significantly increased prevalence among females than males using *DSM-5* (Carmassi et al., 2013; Kilpatrick et al., 2013).

Although heterogeneity may provide a more thorough scope and representation of traumatic responses, the considerable variation in behavioral presentation may lead to confusion among both counselors and clients (Friedman, 2013). Two clients may present in drastically different manners, but receive the same diagnosis. One client with PTSD may be distrustful, experience violent nightmares and behave aggressively, while another with a PTSD diagnosis is more withdrawn and self-blaming, with internally directed negative emotionality. Conversely, a counselor could have two clients who present analogously; and yet, due to the nature of the traumatic event, one could be diagnosable and the other not. This may cause complications for counselors in providing psychoeducation or in determining appropriate clinical interventions.

Counselors will encounter many questions with the changing and heterogeneous face of PTSD. For instance, would a counselor work differently with the client with a PTSD diagnosis than with a client having an analogous presentation, but no PTSD diagnosis? Do neurological ramifications differ dramatically now given

the shifting labels, and thus call for varied interventions? How does a counselor explain to a client who had PTSD under the *DSM-IV* that she or he no longer meets criteria nor qualifies for reimbursement with the new diagnosis of adjustment disorder? Or will adjustment disorder, re-categorized as a TSRD in *DSM-5*, now be recognized by third-party payment systems as a reimbursable disorder? Although some answers are beginning to unfold, an increased awareness and adaption of trauma assessment, treatment and administration can help counselors navigate such questions and effectively work with clients.

Client Assessment

Changes precipitated by the *DSM-5* require counselors be acutely aware of the modified PTSD diagnostic criteria for careful assessment of survivors. Thorough assessment includes applying both informal and formal approaches, using multiple sources of information, and conducting initial and ongoing screenings. During the present transition, informal assessment becomes especially important as efforts to revise and validate formal assessment tools continue.

Informal assessment. Given the central importance of trauma exposure in client care, counselors may continue to struggle to sensitively solicit needed information early in the counseling process. Honed skills for developing and continually fostering the therapeutic alliance are essential to client disclosure and in conscientiously deciphering such information. Some clients may be more reticent to share information, while others may reveal very detailed accounts of their story. In either case, counselors need to remain cognizant of the risk for re-traumatization during this process and pace sessions accordingly. Friedman (2013) also recognized that the current conceptualization of trauma in the *DSM-5* insinuates the trauma has already happened, and that the individual is now "in a context of relative safety" (p. 763). This assumption may complicate assessment of individuals in enduring traumatic environments (e.g., partner violence).

During informal assessment with adults, counselors should practice acute observation skills for nonverbal clues that may signal present intrusive, numbing, arousal and dissociative symptomatology. Reported experiences of feeling detached from body or mind and reports of the world seeming dreamlike or unreal are primary indicators of dissociative experiences. Objective cues of dissociative responses also may be present, such as the client appearing to *space out* (Briere & Scott, 2013). Further, behavioral responses such as reckless and self-destructive behavior must also be recognized as potential trauma responses. The two new criterion D symptoms related to client cognitions, however, require counselors to determine a survivor's cognitive perception of the event, self and world, and how perceptions of the latter two may have shifted post-trauma. Moreover, given the current distinction between numbing and avoidance symptoms, counselors may need to discern conscious from unconscious motivations behind client behaviors.

In children, informal assessment of traumatic responses, although now facilitated by developmentally appropriate criteria, may be particularly challenging. This requires keen observation of behavior, interpersonal interactions, sleep patterns and play. Cohen et al. (2010) suggested that child assessments must account for the onset of symptoms and changing patterns therein to avoid potential misdiagnoses. Recognizing how trauma responses manifest in children will help counselors correctly identify child survivors and help children get the mental health care needed to avert potentially protracted concerns across the life span.

Formal assessment. Formal assessment methods consistent with the revised diagnostic criteria are an essential adjunct to a counselor's informal assessment. A notable addition to the *DSM-5* is the provision of diagnostic assessments. Many are still considered "emerging," as the APA continues to gather feedback from clinicians (APA, 2014). Counselors can familiarize themselves with these measures and stay updated on their availability and validation through the *DSM-5* website (www.psych.org/practice/dsm/dsm5).

Relevant formal measures of PTSD for the *DSM-5* include the following: Level 1 Cross-Cutting Symptom Measures for brief assessment, Level 2 measures for in-depth domain-specific assessment, disorder-specific Severity Measures, and potentially Early Development and Home Background Forms (APA, 2014). *Level 1* surveys include questions related to avoidance, sleep quality, repetitive unpleasant thoughts and other symptoms found in *DSM-5* PTSD criteria. This level provides a measure for adults, a self-rated measure for children ages 11 to 17, and a guardian-rated measure for children ages 6 to 17. *Level 2* Cross-Cutting Symptom Measures allow for more in-depth explorations of symptoms. Disorder-Specific Severity Measures contain the National Stressful Events Survey PTSD Short Scales for adults and for children ages 11-17. Although guardian measures are available, the applicable age range is limited from 6 to 17 years. Thus these measures are not appropriate for assessing symptoms in preschool children, despite the addition of distinct diagnostic criteria for this population.

In addition to the *DSM-5* measures provided by the APA, the National Center for PTSD updated three measures to include *DSM-5* criteria: the Clinician-Administered PTSD Scale for *DSM-5* (CAPS-5), the PTSD Checklist for *DSM-5* (PCL-5), and the Life Events Checklist for *DSM-5* (LEC-5). Counselors wanting to access these measures can submit requests on the National Center for PTSD's website (www.ptsd.va.gov/).

Differential diagnosis: A resource with limitations. Another component of assessment is differential diagnosis. The use of updated measures for formal assessment may not always resolve confusion engendered by facets of *DSM-5* diagnosis such as overlapping criteria. Selecting among the Level 2 cross-cutting measures may be challenging, as many currently focus on anxiety, anger and inattention, which may not be applicable or adequate in assessing PTSD. Differential diagnosis may help counselors gain needed clarity and is often considered integral to every initial clinical encounter and the basis for treatment planning (First, 2014).

Decision trees allow for diagnostic determination based on the entirety of a client's presenting symptoms and assist in identifying diagnostic options by using lists of symptoms relevant to PTSD, including distractibility, mood concerns, suicidal behavior, anxiety, avoidance and insomnia. Out of the 29 available decision trees in the *DSM-5* Handbook of Differential Diagnosis (First, 2014), nine include decisions that may result in an accurate diagnosis of PTSD or another TSRD, not including lists with adjustment disorder as the sole TSRD.

However, some decision trees, which include symptoms reflective of PTSD criteria, do not include the disorder as a possible conclusion. For instance, criterion D covers "negative alterations in cognitions and mood," though none of the three decision trees associated with mood include PTSD. The new symptom in criterion E is "self-destructive or reckless behavior," yet the Decision Tree for Suicidal Ideation or Behavior does not include PTSD as a possible diagnosis, nor does its counterpart for self-injury or self-mutilation. Thus, in the initial absence of information about a precipitating event, well-developed informal assessment skills for PTSD may be the best tool a counselor can use to form initial hypotheses for client conceptualization and associated treatment planning.

Treatment

New changes to the *DSM* also engender implications for PTSD treatment. As noted, the four-factor model of PTSD discriminates between avoidance and negative emotionality/numbing. This transition emphasizes the need to address these two constructs as unique symptom sets in survivors and highlights the influence of neuroscience research on best practices in trauma care. For instance, positive emotional numbing is considered a neurologically based symptom outside the conscious control of survivors, as opposed to the conscious or conditioned behavioral-based responses of effortful avoidance used to decrease arousal (Asmundson et al., 2004). The degree of emotional numbing versus avoidance in clients (or vice versa) suggests differential subpopulations of survivors and thus treatment approaches. For example, exposure therapy has proven

particularly beneficial for avoidance symptoms (Asmundson et al., 2004). However, given the longstanding conceptual overlap in avoidance and numbing symptoms, optimal measures to assess treatment responses to emotional numbing have been limited (Orsillo, Theodore-Oklota, Luterek, & Plumb, 2007). Such findings suggest that effective treatment for trauma clients may become increasingly multidimensional and multidisciplinary.

The addition of new symptoms within criterion E and subtypes of PTSD calls for modified treatment approaches and goals for survivors who fulfill such criteria. For example, the inclusion of reckless or self-destructive behaviors as a feature of hyperarousal in criterion E now encompasses suicidal behavior (Friedman, 2013). Researchers have long denoted strong correlations between PTSD and suicide risk (Krysinka & Lester, 2010). The inclusion of self-destructive behavior as a symptom finally gives credence to this relationship. Counselors should practice vigilance and responsiveness to warning signs of suicidality. Regarding treatment, distress tolerance was shown to moderate PTSD and suicidal behavior (Anestis, Tull, Bagge, & Gratz, 2012), although perceived social support may buffer the impact of trauma symptoms on such behavior (Panagioti, Gooding, Taylor, & Tarrier, 2014). Similarly, the addition of dissociative subtypes highlights the severity and uniqueness of this subpopulation and the need for appropriate treatment considerations. Cloitre et al. (2012) endorsed a staged treatment emphasizing affective and interpersonal regulation as one option for treating dissociation in PTSD.

The addition of a preschool PTSD diagnosis increases the discernible importance of trauma-informed counseling with children and families. Research on best practices with children 6 years old and younger supports the use of cognitive-behavioral therapy (CBT), individually or in groups, most notably Trauma-Focused CBT; as well as child-parent relational psychotherapy; EMDR; and play therapy (Scheeringa, 2014). Scheeringa stressed that the key to working with this age group is engaging the child in developmentally appropriate methods that respect linguistic and introspective abilites (2014). Although some treatment implications stemming from the *DSM-5* are presently discernible, additional research on best practices for addressing novel symptoms and symptom patterns of PTSD in children and adults will further inform practice.

Reimbursement and Legal Ramifications

Additional implications of *DSM-5* modifications, such as healthcare consequences, remain largely unknown. General healthcare implications are explored in a file provided on the *DSM-5* website (APA, 2013b), with the major foci including International Classification of Diseases (ICD) coding and assessment of disability and functioning. The APA (2013b) assured "periodic updates of agreements with federal agencies, private insurance companies, and medical examination boards as they become available" (p. 4). It can be expected that insurance companies will continue to reimburse for PTSD. However, a parallel expectation or hope is for companies to begin reimbursing more consistently for subthreshold PTSD, adjustment disorder and related diagnoses.

Conclusion

Although the changes to PTSD in the *DSM-5* were empirically based and arose after considerable analysis and debate, several areas of concern and oversight still stand. Research remains mixed about overall prevalence rates of vicarious trauma (VT) in mental health practitioners (Kadambi & Ennis, 2004). Given the inclusion of VT in trauma definitions, the expected increase of PTSD diagnoses in clients, and the related potential for reimbursement and access to care for a broader range of traumatized clients, the prevalence of VT in clinicians may increase as well. Further research is needed on prevalence, risk and protective factors, and effective help for counselors experiencing VT. The addition of VT in the *DSM-5* provides a diagnostic construct, yet future research will yield notable contributions to conceptualization and inform counseling practices for individuals experiencing VT.

Furthermore, a growing body of evidence suggests that a traditional diagnosis of PTSD is not sufficient to describe the range and intensity of symptomatology experienced in survivors of unremitting and recurrent abuse, notably abuse during early stages of development. Research has determined that such iterative and early trauma engenders symptomatic sequelae divergent from adult onset or isolated acts of violence (Herman, 1992b; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Herman (1992b) and van der Kolk et al. (2005) proposed a diagnostic formulation distinct from PTSD: complex PTSD or disorders of extreme stress not otherwise specified (DESNOS). The profoundly disruptive nature of DESNOS led researchers to characterize complex PTSD as an experience of "mental death" (p. 617; Ebert & Dyck, 2004). In field trials on the addition of complex PTSD in forthcoming editions of *DSM*, 68% of children who experienced sexual abuse were found to have complex PTSD over and above an expression of PTSD alone (Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997). In a follow-up to earlier field trial studies, van der Kolk et al. (2005) found early interpersonal trauma gives rise to more complex pathology than later interpersonal victimization, and that the younger the age of onset of the trauma, the more likely the individual is to suffer from C-PTSD. However, at the time of the *DSM-5*'s publication, the TSRDD Sub-Work Group of the *DSM-5* determined that there was not currently enough information on the distinctiveness and pervasiveness of the disorder to warrant a formal diagnosis (Friedman, 2013). However, the group incorporated certain proposed DESNOS symptoms (e.g., self-destructive behavior, dissociative subtype) into the reformulated diagnosis (Friedman et al., 2011). Given evidence of uniquely deleterious consequences of early and repeated trauma, ongoing conceptualization and validation of DESNOS will be essential.

Although the *DSM-5* provides improvements to PTSD diagnoses, it also presents notable challenges and engenders numerous unanswered questions for counselors and other mental health professionals. Counselor experiences in the field will inform practice, and continued research will provide more coherent understanding of criteria such as negative emotionality and numbing, accurate assessment of TSRDs, and ramifications in legal, health care and forensic settings. To continue to work ethically within their scope of practice (American Counseling Association, 2014), counselors must ensure that they are trained in the area of trauma and continue to seek professional education and guidance on the ongoing developments in this topic.

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References

American Counseling Association. (2014). *2014 ACA code of ethics*. Alexandria, VA: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

American Psychiatric Association. (2013b). *Insurance implications of DSM-5*. Retrieved from http://www.psychiatry.org/File%20Library/Practice/DSM/DSM-5/Insurance-Implications-of-DSM-5.pdf

American Psychiatric Association. (2014). *Online assessment measures*. Retrieved from http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures

Anestis, M. D., Tull, M. T., Bagge, C. L., & Gratz, K. L. (2012). The moderating role of distress tolerance in the relationship between posttraumatic stress disorder symptom clusters and suicidal behavior among trauma exposed substance users in residential treatment. *Archives of Suicide Research*, *16*, 198–211. doi:10.1080/13811118.2012.695269

Arvay, M. J., & Uhlemann, M. R. (1996). Counsellor stress in the field of trauma: A preliminary study. *Canadian Journal of Counselling and Psychotherapy*, *30*, 193–210.

Asmundson, G. J. G., Stapleton, J. A., & Taylor, S. (2004). Are avoidance and numbing distinct PTSD symptom clusters? *Journal of Traumatic Stress*, *17*, 467–475. doi:10.1007/s10960-004-5795-7

Breslau, N., & Kessler, R. C. (2001). The stressor criterion in DSM-IV posttraumatic stress disorder: An empirical investigation. *Biological Psychiatry*, *50*, 699–704. doi:10.1016/s0006-3223(01)01167-2

Breslau, N., Reboussin, B. A., Anthony, J. C., & Storr, C. L. (2005). The structure of posttraumatic stress disorder: Latent class analysis in 2 community samples. *Archives of General Psychiatry*, *62*, 1343–1351. doi:10.1001/archpsyc.62.12.1343

Brewin, C. R., Lanius, R. A., Novac, A., Schnyder, U., & Galea, S. (2009). Reformulating PTSD for *DSM-V*: Life after Criterion A. *Journal of Traumatic Stress*, *22*, 366–373. doi:10.1002/jts.20443

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation and treatment.* Thousand Oaks, CA: Sage.

Briere, J. N., & Scott, C. (2013). *Principles of trauma therapy: A guide to symptoms, evaluation and treatment* (2nd ed.). Thousand Oaks, CA: Sage.

Carmassi, C., Akiskal, H. S., Yong, S. S., Stratta, P., Calderani, E., Massimetti, E., . . . Dell'Osso, L. (2013). Post-traumatic stress disorder in DSM-5: Estimates of prevalence and criteria comparison versus DSM-IV-TR in a non-clinical sample of earthquake survivors. *Journal of Affective Disorders*, *151*, 843–848. doi:10.1016/j.jad.2013.07.020

Cloitre, M., Petkova, E., Wang, J., & Lu, F. (2012). An examination of the influence of a sequential treatment on the course and impact of dissociation among women with PTSD related to childhood abuse. *Depression and Anxiety*, *29*, 709–717. doi:10.1002/da.21920

Cohen, J. A., Bukstein, O., Walter, H., Benson, R. S., Chrisman, A., Farchione, T. R., . . . Medicus, J. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, *49*, 414–430.

Cook, J. M., Rehman, O., Bufka, L., Dinnen, S., & Courtois, C. (2011). Responses of a sample of practicing psychologists to questions about clinical work with trauma and interest in specialized training. *Psychological Trauma: Theory, Research, Practice, and Policy*, *3*, 253–257. doi:10.1037/a0025048

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 standards*. Retrieved from http://www.cacrep.org/wp-content/uploads/2013/12/2009-Standards.pdf

Creamer, M., McFarlane, A. C., & Burgess, P. (2005). Psychopathology following trauma: The role of subjective experience. *Journal of Affective Disorders*, *86*, 175–182. doi:10.1016/j.jad.2005.01.015

Cukor, J., Wyka, K., Jayasinghe, N., & Difede, J. (2010). The nature and course of subthreshold PTSD. *Journal of Anxiety Disorders*, *24*, 918–923. doi:10.1016/j.janxdis.2010.06.017

Ebert, A., & Dyck, M. J. (2004). The experience of mental death: The core feature of complex posttraumatic stress disorder. *Clinical Psychology Review*, *24*, 617–635. doi:10.1016/j.cpr.2004.06.002

Felmingham, K., Kemp, A. H., Williams, L., Falconer, E., Olivieri, G., Peduto, A., & Bryant, R. (2008). Dissociative responses to conscious and non-conscious fear impact underlying brain function in post-traumatic stress disorder. *Psychological Medicine*, *38*, 1771–1780. doi:10.1017/S0033291708002742

First, M. B. (2014). *DSM-5 Handbook of Differential Diagnosis*. Arlington, VA: American Psychiatric Association.

Fish, V. (2004). Some gender biases in diagnosing traumatized women. In P. J. Caplan & L. Cosgrove (Eds.), *Bias in psychiatric diagnosis* (pp. 213–220). Lanham, MD: Rowman & Littlefield.

Foa, E. B., Riggs, D. S., & Gershuny, B. S. (1995). Arousal, numbing, and intrusion: Symptom structure of PTSD following assault. *The American Journal of Psychiatry*, *152*, 116–120.

Foa, E. B., Zinbarg, R., & Rothbaum, B. O. (1992). Uncontrollability and unpredictability in post-traumatic stress disorder: An animal model. *Psychological Bulletin*, *112*, 218–238. doi:10.1037/0033-2909.112.2.218

Freud, S. (1962). The aetiology of hysteria. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud, Volume III (1893-1899): Early psycho-analytic publications* (pp. 187–221). London, England: Hogarth Press.

Frewen, P. A., Dozois, D. J. A., Neufeld, R. W. J., Densmore, M., Stevens, T. K., & Lanius, R. A. (2010). Social emotions and emotional valence during imagery in women with PTSD: Affective and neural correlates. *Psychological Trauma: Theory, Research, Practice, and Policy*, *2*, 145–157. doi:10.1037/a0019154

Friedman, M. J. (2013). Finalizing PTSD in *DSM-5*: Getting here from there and where to go next. *Journal of Traumatic Stress*, *26*, 548–556. doi:10.1002/jts.21840

Friedman, M. J., Resick, P. A., Bryant, R. A., & Brewin, C. R. (2011). Considering PTSD for DSM-5. *Depression and Anxiety*, *28*, 750–769. doi:10.1002/da.20767

Galatzer-Levy, I. R., & Bryant, R. A. (2013). 636,120 ways to have posttraumatic stress disorder. *Perspectives on Psychological Science*, *8*, 651–662. doi:10.1177/1745691613504115

Herman, J. L. (1992a). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York, NY: Basic Books.

Herman, J. L. (1992b). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*, 377–391. doi:10.1002/jts.2490050305

Kadambi, M. A., & Ennis, L. (2004). Reconsidering vicarious trauma: A review of the literature and its' [sic] limitations. *Journal of Trauma Practice*, *3*, 1–21. doi:10.1300/J189v03n02_01

Kelley, L. P., Weathers, F. W., McDevitt-Murphy, M. E., Eakin, D. E., & Flood, A. M. (2009). A comparison of PTSD symptom patterns in three types of civilian trauma. *Journal of Traumatic Stress*, *22*, 227–235. doi:10.1002/jts.20406

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using *DSM-IV* and *DSM-5* criteria. *Journal of Traumatic Stress*, *26*, 537–547. doi:10.1002/jts.21848

Krysinska, K., & Lester, D. (2010). Post-traumatic stress disorder and suicide risk: A systematic review. *Archives of Suicide Research*, *14*, 1–23. doi:10.1080/13811110903478997

Lanius, R. A., Brand, B., Vermetten, E., Frewen, P. A., & Spiegel, D. (2012). The dissociative subtype of posttraumatic stress disorder: Rationale, clinical and neurobiological evidence, and implications. *Depression and Anxiety*, *29*, 701–708. doi:10.1002/da.21889

McNally, R. J. (2009). Can we fix PTSD in DSM-V? *Depression and Anxiety*, *26*, 597–600. doi:10.1002/da.20586

Meldrum, L., King, R., & Spooner, D. (2002). Secondary traumatic stress in case managers working in community mental health services. In C. R. Figley (Ed.), *Treating compassion fatigue* (pp. 85–106). New York, NY: Brunner-Routledge.

Moser, J. S., Hajcak, G., Simons, R. F., & Foa, E. B. (2007). Posttraumatic stress disorder symptoms in trauma-exposed college students: The role of trauma-related cognitions, gender, and negative affect. *Journal of Anxiety Disorders*, *21*, 1039–1049. doi:10.1016/j.janxdis.2006.10.009

Nemeroff, C. B., Weinberger, D., Rutter, M., MacMillan, H. L., Bryant, R. A., Wessely, S., . . . Lysaker, P. (2013). DSM-5: A collection of psychiatrist views on the changes, controversies, and future directions. *BMC Medicine*, *11*, 1–19. doi:10.1186/1741-7015-11-202

Orsillo, S. M., Theodore-Oklota, C., Luterek, J. A., & Plumb, J. (2007). The development and psychometric evaluation of the Emotional Reactivity and Numbing Scale. *Journal of Nervous & Mental Disease*, *195*, 830–836. doi:10.1097/NMD.0b013e318156816f

Panagioti, M., Gooding, P. A., Taylor, P. J., & Tarrier, N. (2014). Perceived social support buffers the impact of PTSD symptoms on suicidal behavior: Implications into suicide resilience research. *Comprehensive Psychiatry*, *55*, 104–112. doi:10.1016/j.comppsych.2013.06.004

Parker, M., & Henfield, M. S. (2012). Exploring school counselors' perceptions of vicarious trauma: A qualitative study. *The Professional Counselor*, *2*, 134–142.

Pynoos, R. S., Steinberg, A. M., Layne, C. M., Briggs, E. C., Ostrowski, S. A., & Fairbank, J. A. (2009). *DSM-V* PTSD diagnostic criteria for children and adolescents: A developmental perspective and recommendations. *Journal of Traumatic Stress*, *22*, 391–398. doi:10.1002/jts.20450

Rojas, V. M., & Lee, T. N. (2004). Childhood vs. adult PTSD. In R. R. Silva (Ed.), *Posttraumatic stress disorders in children and adolescents: Handbook* (pp. 237–256). New York, NY: Norton.

Rosen, G. M., & Lilienfeld, S. O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical Psychology Review*, *28*, 837–868. doi:10.1016/j.cpr.2007.12.002

Roth, S., Newman, E., Pelcovitz, D., van der Kolk, B., & Mandel, F. S. (1997). Complex PTSD in victims exposed to sexual and physical abuse: Results from the DSM-IV field trial for posttraumatic stress disorder. *Journal of Traumatic Stress*, *10*, 539–555. doi:10.1002/jts.2490100403

Royle, L., Keenan, P., & Farrell, D. (2009). Issues of stigma for first responders accessing support for post traumatic stress. *International Journal of Emergency Mental Health*, *11*, 79–85.

Scheeringa, M. S. (2014). *PTSD for children 6 years and younger*. Retrieved from http://www.ptsd.va.gov/professional/PTSD-overview/ptsd_children_6_and_younger.asp

Scheeringa, M. S., Myers, L., Putnam, F. W., & Zeanah, C. H. (2012). Diagnosing PTSD in early childhood: An empirical assessment of four approaches. *Journal of Traumatic Stress*, *25*, 359–367. doi:10.1002/jts.21723

Scheeringa, M. S., Zeanah, C. H., & Cohen, J. A. (2011). PTSD in children and adolescents: Toward an empirically based algorithma. *Depression and Anxiety*, *28*, 770–782. doi:10.1002/da.20736

Schützwohl, M., & Maercker, A. (1999). Effects of varying diagnostic criteria for posttraumatic stress disorder are endorsing the concept of partial PTSD. *Journal of Traumatic Stress*, *12*, 155–165. doi:10.1023/a:1024706702133

Ullman, S. E., & Long, S. M. (2008). Factor structure of PTSD in a community sample of sexual assault survivors. *Journal of Trauma & Dissociation*, *9*, 507–524. doi:10.1080/15299730802223370

van der Kolk, B. A. (2007). The history of trauma in psychiatry. In M. J. Friedman, T. M. Keane, & P. A. Resick (Eds.), *Handbook of PTSD: Science and practice* (pp. 19–36). New York, NY: The Guilford Press.

van der Kolk, B. A., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Traumatic Stress*, *18*, 389–399. doi:10.1002/jts.20047

Vidal, M. E., & Petrak, J. (2007). Shame and adult sexual assault: A study with a group of female survivors recruited from an East London population. *Sexual and Relationship Therapy*, *22*, 159–171. doi:10.1080/14681990600784143

Yehuda, R., & Bierer, L. M. (2009). The relevance of epigenetics to PTSD: Implications for the DSM-V. *Journal of Traumatic Stress*, *22*, 427–434. doi:10.1002/jts.20448

Zoellner, L. A., Rothbaum, B. O., & Feeny, N. C. (2011). PTSD not an anxiety disorder? DSM committee proposal turns back the hands of time. *Depression and Anxiety*, *28*, 853–856. doi:10.1002/da.20899

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The 2013 publication of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*) marked the reemergence of issues related to the appropriateness of diagnosis and the uses of the *DSM-5* within the counseling profession. Concerns focus on the implications of the *DSM-5* for counseling professionals whose professional identity is grounded in a prevention and wellness model, and the impact of the diagnostic process on counseling ethical practice. In this article, the authors explore the use of the *DSM-5* in counseling training and practice. The authors also discuss integrating *DSM-5* diagnosis into a counselor training framework while maintaining a wellness orientation. Multicultural and strength-based considerations are recommended when using the *DSM-5* in counseling training and practice, while maintaining consistency with a philosophical orientation focused on development and wellness and delivering services that are indicative of a unified counseling professional identity.

***Keywords*: diagnosis, *DSM-5*, strengths, wellness, counselor training, multicultural**

The history of the counseling profession dates back to the vocational guidance movement of the early 1900s. As society became increasingly industrialized, a need arose to improve individuals' vocational choices (Whiteley, 1984). With a focus on helping people to resolve problems in living, the counseling profession has maintained an emphasis on growth, prevention and early intervention across the life span (Gladding, 2013). Counseling is defined as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas, & Gladding, 2013). According to Remley and Herlihy (2014), many problems and issues that people face are developmental in nature. A wellness orientation toward helping and help seeking and the use of holistic approaches to treatment distinguish professional counselors from other mental health professionals (Mellin, Hunt, & Nichols, 2011). A focus on normal development and positive lifestyles promotes counselor professional identity and unifies the counseling profession (Gale & Austin, 2003). Given its common historical roots of assisting individuals with educational, occupational and emotional well-being (Whiteley, 1984), the field of counseling psychology also "maintains a focus on facilitating personal and interpersonal functioning across the life span. . . [with] particular attention to emotional, social, vocational, educational, health-related, developmental, and organizational concerns" (Society of Counseling Psychology, American Psychological Association, Division 17, 2014). Therefore, counselors, counseling psychologists and counselor educators benefit from understanding the dynamics of human growth and development in developing responsive interventions for clients with mental health concerns (Ibrahim, 1991). Furthermore, in creating a shared vision for supporting counselors, services to clients and the counseling profession, "advocat[ing] for optimal human development by promoting prevention

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and wellness" was among the six critical themes identified at the Counselor Advocacy Leadership Conference (Kaplan & Gladding, 2011, p. 368).

With the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5;* American Psychiatric Association [APA], 2013), issues related to counselor professional identity, diagnosis and the use of the *DSM-5* within the counseling profession have reemerged. Concerns focus on the implications of the *DSM-5* for counseling professionals who advocate prevention and wellness, and the impact of the diagnostic process on counseling ethical practice (Kress, Hoffman, Adamson, & Eriksen, 2013). Also, multicultural and contextual considerations may be ignored when adhering to a medical model implied by the *DSM* system. Despite these criticisms, few models exist for integrating diagnosis using the *DSM-5* into a wellness and prevention orientation, which is central to professional counseling training and practice. Our goal is to explore the use of the *DSM-5* in counseling training and practice, and to suggest ways that *DSM-5* diagnosis might be integrated into a counselor training framework while maintaining a wellness orientation.

DSM and Counseling Training

Distinguishing counseling from other mental health professions by a focus on human development, prevention and wellness does not exclude counseling professionals and trainees from acquiring an understanding of behavior across the adaptive-maladaptive continuum. In promoting a counselor professional identity, and reinforcing the consensus definition of professional counseling as empowering individuals, families and groups, teaching diagnosis using the *DSM-5* to counseling trainees requires a cultural and contextual understanding of individuals and their concerns. Providing counseling trainees with learning experiences designed to foster knowledge and skills extends beyond exposure to the *DSM-5* classification systems for categorizing behavior identified as disordered. Successfully integrating knowledge, skills and practices of diagnosis and the *DSM-5* into counselor education involves a review of counselor common core curricular and professional practice (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009).

In the requirements for common core curricular experiences and demonstrated knowledge, CACREP (2009) requires that all counseling trainees learn about "the nature and needs of persons at all developmental levels and in multicultural contexts" (II.G.3, p. 10), including "theories for facilitating optimal development and wellness over the life span" (II.G.3.h, p. 10) and about "human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior" (II.G.3.f, p. 10). Furthermore, the standards for Addiction Counseling and Clinical Mental Health Counseling specifically require demonstrated "professional knowledge, skills, and practices" (CACREP, 2009, III, p. 17; p. 29), use of the current *DSM* and use of other diagnostic tools. Therefore, in addition to common core curricular experiences that develop knowledge and skills needed for "facilitating optimal development and wellness over the life span" (CACREP, 2009, II.G.3.h, p. 10), professional counselors must have diagnostic knowledge, skills and practices. This includes understanding "etiology, the diagnostic process and nomenclature, treatment, referral, and prevention of mental and emotional disorders" (CACREP, 2009, III.C.2, p. 30) and "the range of mental health service delivery" (III.C.5, p. 30). Specifically, CACREP (2009) standards require that counseling trainees must evidence knowledge, relevant skills and practices that include the following: knowledge of the use of the current edition of the *DSM* (i.e., *DSM-5*), an understanding of possible biases that might occur when using diagnostic tools with culturally diverse clients, knowledge of the correct use of diagnosis during a traumatic event, and the ability to differentiate "between diagnosis and developmentally appropriate reactions" to traumatic events (CACREP, 2009, III.L.3, p. 34). Moreover, in demonstrating knowledge, skills and practices of the diagnostic process, counseling trainees must understand the implications of diagnosis and treatment interventions. To this end, Kress et al. (2013) stressed the importance of weighing

both the benefits and risks of diagnosis when working with clients.

DSM-5 and Counseling Practice

Despite goals of revising the diagnostic classification scheme to make it "more clinically valuable and more biologically valid" (Nemeroff et al., 2013, p. 2), and of acknowledging cultural variations in clients' expressions of their concerns (Brown & Lewis-Fernández, 2011), the *DSM-5* has been criticized from within and beyond the psychiatric community. Released in May 2013, the *DSM-5* was met with controversy from mental health professionals and organizations representing their interest in providing effective clinical mental health services to clients (Washburn, 2013). Many viewed the *DSM-5* as an extension of the traditional medical model of diagnosis. For example, Ladd (2013) criticized *DSM* diagnosis for (1) ignoring the therapeutic alliance as a critical aspect of treatment; (2) depending on "statistically acquired symptoms" and "specific rules and timelines" created by Task Force/Work Group professional experts (p. 2); and (3) gearing its usefulness toward "insurance companies, managed care agencies and other professionals in the health care system" (p. 3). The American Mental Health Counselors Association (AMHCA) *DSM-5* Task Force (2012), among other groups, submitted feedback to improve the *DSM-5* draft. Although the *DSM* provides a common language for presenting client problems (Hinkle, 1999), the language and assumptions associated with the criteria for diagnosis became the focus of criticism. Stressing the important distinction of "separating the art of mental health diagnosis and complying with the mental health diagnosis business," Ladd (2013, p. 3) described the *DSM* as "the diagnostic instrument for the 'mental health diagnosis business' with categories and labels used as the language for insurance reimbursement, pharmaceutical treatment, and collaboration between experts" (p. 3).

Due to a growing need for quality mental health services, counseling professionals are providing services to clients presenting with a diverse range of concerns. Counselors are often required to diagnose clients' problems using the *DSM*-5 (Miller & Prosek, 2013). *DSM* diagnosis is necessary for counselors to access managed care and insurance company reimbursements (Hinkle, 1999). However, a traditional use of the *DSM* may pathologize behavior and separate diagnosis from treatment interventions (Ivey & Ivey, 1999). Counselors faced with these ethical dilemmas may question their professional identity, the usefulness of a wellness orientation and the effectiveness of counseling-related tasks (McAuliffe & Eriksen, 1999; Mellin et al., 2011). Counselors' challenge to adhere to a wellness orientation as the foundation of their professional identity may be further tested by other mental health professionals' tendency to conceptualize health and illness using models of pathology and remediation (McAuliffe & Eriksen, 1999). These dilemmas in counseling practice are more likely to become problematic when counselors are not grounded in a strong professional identity. Gale and Austin (2003) encouraged counselors to embrace a wellness model rather than an illness or deficit model of help seeking and treatment planning. Counselor clinical judgment is critical to the diagnostic process. Notwithstanding criticisms of the *DSM*, Johnson (2013) asserted that diagnosis is directly related to the philosophical and theoretical orientations of the clinician. The medical model used in diagnosis negatively impacts clients' willingness to seek help for their concerns, and also influences mental health professionals' orientations toward deficit models (McAuliffe & Eriksen, 1999).

Important considerations for teaching the *DSM* are directly related to understanding the diagnostic process and implications for models of helping used to conceptualize counseling goals and interventions with clients. Given the focus on prevention, wellness and health across the life span, key questions arise when teaching the *DSM-5* to counseling trainees from a traditional medical model that is "focused disproportionately on the physical aspects of illness" (Ingersoll, 2002, p. 115). A traditional disease model views the helper as the expert responsible for healing the client (McAuliffe & Eriksen, 1999). Brickman et al. (1982) viewed this model of helping as deficient in that the helper fosters dependency, which is antithetical to an empowering therapeutic relationship. Teaching the *DSM-5* to counseling students requires an understanding of a developmental and wellness orientation. Models of helping must be philosophically and theoretically congruent with a professional

counseling identity. To this end, counseling trainees must be challenged to examine their beliefs about seeking help and their view of a helper in the counseling relationship. Diagnosis and treatment should not be separate; rather, diagnosis should occur in conjunction with treatment (Ivey & Ivey, 1999). Viewing clients from a holistic perspective assumes that the greatest source of information lies within the client, not a manual or system of classifying disorders. Focusing on clients' strengths rather than deficiencies helps to empower clients as part of their learning and development. Integrating multicultural and strength-based considerations as part of the diagnostic process helps to ensure that clients receive culturally responsive counseling interventions.

Integrating Multicultural and Strength-Based Considerations

Counselors, counseling psychologists and counselor educators have been instrumental in recognizing the role of culture and integrating multicultural perspectives in an attempt to understand behavior more fully (Pedersen, 1991; Sue, Sue, Sue, & Sue, 2014). Although racial-ethnic minority groups remained underrepresented in research examining psychopathology, African-American and Hispanic or Latino clients are more likely to be diagnosed, to receive diagnoses of greater severity and to experience less effective treatment outcomes than are White clients (Johnson, 2013; Sue & Sue, 2013). Consequently, multicultural counselor competencies are necessary to address counselors' culturally biased assumptions and to increase counseling effectiveness in a society changing in culture and diversity (Arredondo et al., 1996; Pedersen, 1987, 2003; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Sue & Sue, 2013). Multiculturalism integrates culturally specific and universal perspectives in explaining the dynamics of behavior and developing culturally responsive approaches to treatment. However, counselors may ignore multicultural considerations when adhering to a medical model implied by the *DSM*. Ivey and Ivey (1999) called on counseling professionals to apply multicultural perspectives when using the *DSM*. In advancing a contextual understanding of behavior and disorders, Sue et al. (2014) developed a multipath model using four dimensions (i.e., biological, psychological, social and sociocultural) to describe etiological explanations of abnormal behavior.

Social, cultural and economic considerations must be acknowledged when attempting to identify and classify behavior diagnosed as maladaptive. Sue et al. (2014) distinguished cultural universality from cultural relativity in describing behavior within a sociocultural context. Important cultural nuances may be misunderstood when viewed by others who are culturally dissimilar. The result is the labeling of culturally normal behavior as maladaptive. To this end, myths associated with abnormal behavior have led to the social construction of diagnostic categories, which have been cited as major criticisms of using the *DSM*. Among these faulty assumptions is the belief that abnormal behavior can be readily recognized, distinguished from normal behavior and therefore categorized according to a diagnostic classification scheme (Maddux, 2002; Sue et al., 2014). Maddux (2002) further stated that diagnostic categories used in making biased clinical judgments lead to culturally unresponsive treatment interventions. Inherent in this approach is the basis of the medical model, in which clients are more often treated for pathological behavior (McAuliffe & Eriksen, 1999).

A step toward more holistic diagnostic practices appeared in the *DSM-5* in the form of dimensional rather than categorical assessments. These dimensional assessments of every categorical diagnosis were designed to assist counselors with diagnosis and treatment planning (Jones, 2012). Unlike previous versions of the *DSM* that used a categorical system, dimensional assessments view disorders on a continuum, representing varying degrees of a behavior (Sue et al., 2014). The dimensional assessment also allows counselors to consider individual differences and the influences of race and culture (Johnson, 2013). With the dimensional model, counselors are able to determine whether a diagnostic criterion is present and rate its severity (Brown & Lewis-Fernández, 2011). Viewing disorders on a continuum of behavior may decrease comorbidity; however, it also may affect clients' accessibility to services by eliminating clients who might have formerly met the criteria for diagnosis or diagnosing clients with a disorder that would have been excluded based on the former criteria.

Examples include autism spectrum disorder and depression resulting from bereavement, respectively. Given these changes, the effect of the *DSM-5* on diagnosis may impact clients' access to mental health services and create ethical dilemmas for counselors related to over- and undertreatment.

In addition to the dimensional assessments, the *DSM-5* also contains disorders associated with cultural issues. Psychosocial factors are included by using V codes from the World Health Organization's (WHO) *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*; WHO, 1979) and Z codes from the *International Classification of Diseases, Tenth Revision* (*ICD-10*; WHO,1992), as well as three new terms: cultural syndrome, cultural idiom of distress and cultural explanation or perceived cause (Pomeroy & Anderson, 2013). Counselors must become familiar with the *ICD-10-CM* diagnostic codes, which will become the standard medical coding system in the United States beginning October 1, 2015. Inclusion of psychosocial factors evidences the relationship between psychosocial factors and mental health. Multicultural considerations in diagnosis allow mental health practitioners to understand cultural and individual characteristics that define identity and experience. These characteristics of a client's identity are multiple and interlocking. The uniqueness that defines a client may be lost if group generalizations as represented by the *DSM-5* are used as the only means of understanding a client's experiences. Critical to understanding clients and their stories is the ability to conceptualize clients as individuals interacting within the sociocultural context in which they live. This also involves hearing clients' stories from their perspective, using their own words.

The importance of cultural influences on mental health diagnosis also is demonstrated by the inclusion of the Cultural Formulation Interview (CFI; Pomeroy & Anderson, 2013). The CFI was developed to improve cross-cultural diagnostic assessment and was created from the Outline for Cultural Formulation (OCF) of the *DSM-IV* (Aggarwal, Nicasio, DeSilva, Boiler, & Lewis-Fernández, 2013). In keeping with multicultural competency models, the CFI provides a way for counselors to explore and understand clients' experiences and worldviews, as well as clients' cultural explanations and interpretations of their concerns. However, Aggarwal et al. (2013) cautioned that the overstandardization of the CFI may result in counselor and client barriers such as the following: a counselor misunderstanding the problem and the problem severity, a lack of conceptual relevance between the client's concern and counseling interventions, and a counselor and client's lack of acceptance and unwillingness to engage in the process. Counselors' ability to develop authentic and caring relationships is essential to accurate diagnosis and relevant counseling interventions. When clients are viewed as unique and counselors understand their experiences, accurate diagnosis and ethical practice are ensured (Swartz-Kulstad & Martin, 1999).

Moving beyond an illness model toward a counselor-client collaborative wellness model begins with a process of engaging with the client, gathering the information needed for assessing the client and trusting in the therapeutic alliance to accomplish the goals of treatment (Ivey & Ivey, 1999). Contrary to the medical or illness model, in which the client's weaknesses or deficiencies precipitate the diagnosis, treatment and policy decisions, the integration of a strength-based framework and counselor preparation ensures a holistic approach to assessment and treatment (Wright & Lopez, 2002). Working with clients from a holistic perspective requires knowledge and skills that preserve the integrity of the counseling profession by embracing multicultural and strength-based considerations. A framework adapted from positive psychology, defined as "the study of . . . what is 'right' about people—their positive attributes, psychological assets, and strengths" (Kobau et al., 2011, p. e1), assists in bolstering resilience and promoting mental health.

Strength-Based Approaches to Diagnosis

Character Strengths and Virtues

Character Strengths and Virtues: A Handbook and Classification (*CSV*; Peterson & Seligman, 2004),

which its authors dub a "Manual of the Sanities" (p. 3) in the introductory chapter, was developed in part as a companion to the *DSM* that focuses on classifying what is right about people. It includes explicit criteria for character strengths and launched the development of several assessment tools that aid in diagnosing one's strengths in the way that the *DSM* diagnoses one's limitations. Character strengths are the foundation of strength-based approaches and provide a way to assess client functioning from a wellness orientation (O'Hanlon & Bertolino, 2012). The *CSV* distinguishes three conceptual levels: (1) virtues: core characteristics that moral and religious philosophers esteem; (2) character strengths: processes that define virtues; and (3) situational themes: practices that lead people to establish specific character strengths in certain situations.

Parallel to the *DSM*, the *CSV* outlines 10 specific criteria that must be satisfied to warrant inclusion as a character strength. Using these criteria, 24 character strengths were identified under the respective umbrellas of six core virtues: (1) wisdom and knowledge (creativity, curiosity, open-mindedness, love of learning, and perspective); (2) courage (bravery, persistence, integrity, and vitality); (3) humanity (love, kindness, and social intelligence); (4) justice (citizenship, fairness, and leadership); (5) temperance (forgiveness and mercy, humility and modesty, prudence, and self-regulation); and (6) transcendence (appreciation of beauty and excellence, gratitude, hope, humor, and spirituality). The *CSV* also broadly outlines strength assessment strategies, as well as interventions that further cultivate strengths. For example, counselors might assist clients in realizing or reaffirming their virtue of strength of courage by exploring the will to achieve goals while facing external or internal opposition (O'Hanlon & Bertolino, 2012). This exercise empowers clients and provides counselors with a positive rather than a negative assessment of client behavior. Similarly, the use of positive talk moves clients away from a perspective of deficiency and illness toward encouragement and motivation for change.

Using the *CSV* in conjunction with the *DSM* enables counselors to help their clients identify, take pride in and use their character strengths and virtues to enhance well-being in all areas of their lives. Gander, Proyer, Ruch and Wyss (2013) found that using one's signature strengths in a different way lowered depression and boosted happiness for six months. Wood, Linley, Matlby, Kashdan and Hurling's (2011) longitudinal study determined that using one's strengths was correlated with well-being; decreased stress; and greater self-esteem, positive affect and vitality, with the effects still present at three-month and six-month follow-ups. Furthermore, the majority of positive counseling interventions focus on character strength interventions, which have been found to benefit both adults and children dealing with depression and anxiety (Rashid & Anjum, 2008; Seligman, Rashid, & Parks, 2006).

Client diagnosis and conceptualization using the *DSM-5* may be incomplete if clinicians do not consider clients' environmental resources, well-being and strengths (Snyder et al., 2003). Minor alterations to this diagnostic system could promote emphasis on positive functioning and provide information that could contribute to a more complete client picture and conceptualization. Recommendations for rescaling the Axis V Global Assessment of Functioning (GAF) Scale of the *DSM-IV-TR* included creating a functioning baseline, with the current GAF level of 100 (absence of symptomatology) rescaled to a midpoint of 50. This would have encouraged practitioners to identify and use client strengths, with a GAF of 1 representing severely impaired functioning, 50 representing good health and 100 representing optimal functioning. Snyder et al. (2003) also suggested adding personal strengths and growth facilitators through three brief questions and four positive psychology assessments that measure hope, optimism, personal growth initiative and subjective well-being. Similarly, Magyar-Moe (2009) suggested using a seven-axis system of positive psychological assessment that included documenting positive and negative aspects of clients' cultural identities, as well as clients' personal strengths as facilitators of growth.

These exercises, based in positive well-being, are consistent with a wellness orientation of helping and should not be solely limited to clients' growth and development. Counseling trainees and professional

counselors benefit personally and professionally when functioning from a strength-based orientation. For example, based on findings from attribution theory, negative labels affect motivation for change (O'Hanlon & Bertolino, 2012). Therefore, O'Hanlon and Bertolino cautioned against using negative diagnostic labels that may communicate a belief that clients are unable to change. From this perspective, counselors must continually examine their own behavior and the subtle messages that clients might receive during counseling. Through strength-based exercises, counselors are encouraged to promote strengths and resilience as part of an ongoing reflective practice.

Conclusion

Teaching the process of diagnosis using the *DSM-5* to counseling trainees is not an easy undertaking. Developed as a tool that promotes a language for use in the larger mental health system (Hinkle, 1999), the *DSM* is required learning for counseling trainees, and demonstrating professional knowledge, skills and practices is required for professional counselors. Teaching the basic vocabulary and criteria associated with disorders is only the first level of discussion. Effectively teaching diagnosis informed by multicultural and strength-based perspectives includes acknowledging the purpose and limitations of the *DSM-5*, and examining beliefs about helping, and the role and behavior of helpers. Counselors must explore the concept of normal behavior and their ability to identify abnormal behavior, as well as factors influencing growth and change.

Peterson (2013) stated, "we have developed a wonderful vocabulary that explains what goes wrong with folks and we have almost nothing to say about what can go right with folks" (p. 7). Teaching diagnosis and the *DSM-5* integrated with multicultural and strength-based considerations helps counselors to understand what goes right with clients. Through this understanding, clients' strengths, character and virtues become the support for growth and change within the counseling relationship. Rather than focusing on illness and deficiencies, counselors and clients acknowledge strengths and use them to assist clients in resolving problems in life. Informing the diagnostic process with multicultural and strength-based considerations fosters a holistic view of clients and reinforces counselor advocacy of optimal human functioning. Counselors must consider culture, context and strengths for the diagnostic process to be useful in working with clients from a wellness orientation (Adams & Quartiroli, 2010).

Furthermore, multicultural and strength-based practice considerations encourage reflection and counselor reflective practice, which challenge culturally biased assumptions that negatively affect counselor judgments about clients and the diagnostic process. As a result, counseling professionals do not view clients as confined and limited to a diagnosis; rather, they conceptualize clients as resilient and evolving (Adams & Quartiroli, 2010). Recognizing limitations and possibilities of the *DSM-5*, embracing a wellness and holistic orientation, and understanding clients from their cultural and situational contexts with a focus on strengths are critical factors that reduce ethical dilemmas and support the use of the *DSM-5* in counseling training and practice (Adams & Quartiroli, 2010; Gale & Austin, 2003; McAuliffe & Eriksen, 1999). Integrating multicultural and strength-based considerations into counseling training and practice increases the likelihood that counselors will embrace a professional identity congruent with a wellness orientation when using the *DSM-5* as a tool in the diagnostic process (Mannarino, Loughran, & Hamilton, 2007).

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References

Adams, J. R., & Quartiroli, A. (2010). Critical considerations of the *diagnostic and statistical manual*: Importance of the inclusion of cultural and contextual factors. *Journal of Humanistic Counseling, Education and Development*, *49*, 84–97. doi:10.1002/j.2161-1939.2010.tb00089.x

Aggarwal, N. K., Nicasio, A. V., DeSilva, R., Boiler, M., & Lewis-Fernández, R. (2013). Barriers to implementing the DSM-5 Cultural Formulation Interview: A qualitative study. *Culture, Medicine, and Psychiatry*, *37*, 505–533. doi:10.1007/s11013-013-9325-z

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Arredondo, P., Toporek, R., Pack Brown, S., Jones, J., Locke, D. C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development*, *24*, 42–78. doi:10.1002/j.2161-1912.1996.tb00288.x

Brickman, P., Rabinowitz, V. C., Karuza, J., Jr., Coates, D., Cohn, E., & Kidder, L. (1982). Models of helping and coping. *American Psychologist*, *37*, 368–384.

Brown, R. J., & Lewis-Fernández, R. (2011). Culture and conversion disorder: Implications for the DSM-5. *Psychiatry*, *74*, 187–206. doi:10.1521/psyc.2011.74.3.187

Council for Accreditation of Counseling and Related Educational Programs. (2009). *2009 CACREP standards*. Alexandria, VA: Author.

Gale, A. U., & Austin, B. D. (2003). Professionalism's challenges to professional counselors' collective identity. *Journal of Counseling & Development*, *81*, 3–10. doi:10.1002/j.1556-6678.2003.tb00219.x

Gander, F., Proyer, R. T., Ruch, W., & Wyss, T. (2013). Strength-based positive interventions: Further evidence for their potential in enhancing well-being and alleviating depression. *Journal of Happiness Studies*, *14*, 1241–1259. doi:10.1007/s10902-012-9380-0

Gladding, S. T. (2013). *Counseling: A comprehensive profession* (7th ed.). Upper Saddle River, NJ: Pearson.

Hinkle, J. S. (1999). A voice from the trenches: A reaction to Ivey and Ivey (1998). *Journal of Counseling & Development*, *77*, 474–483. doi:10.1002/j.1556-6676.1999.tb02475.x

Ibrahim, F.A. (1991). Contribution of cultural worldview to generic counseling and development. *Journal of Counseling & Development*, *70*, 13–19. doi:10.1002/j.1556-6676.1991.tb01556.x

Ingersoll, R. E. (2002). An integral approach for teaching and practicing diagnosis. *The Journal of Transpersonal Psychology*, *34*, 115–127.

Ivey, A. E., & Ivey, M. B. (1999). Toward a developmental diagnostic and statistical manual: The vitality of a contextual framework. *Journal of Counseling & Development*, *77*, 484–490. doi:10.1002/j.1556-6676.1999.tb02476.x

Johnson, R. (2013). Forensic and culturally responsive approach for the DSM-5: Just the FACTS. *The Journal of Theory Construction & Testing*, *17*, 18–22.

Jones, K. D. (2012). Dimensional and cross-cutting assessment in the *DSM-5*. *Journal of Counseling & Development*, *90*, 481–487. doi:10.1002/j.1556-6676.2012.00059.x

Kaplan, D. M., & Gladding, S. T. (2011). A vision for the future of counseling: The 20/20 *Principles for Unifying and Strengthening the Profession*. *Journal of Counseling & Development*, *89*, 367–372.

Kaplan, D. M., Tarvydas, V. M., & Gladding, S. T. (2013). *20/20: A vision for the future of counseling: The new consensus definition of counseling*. Retrieved from http://www.counseling.org/docs/david-kaplan's-files/consensus-definition-of-counseling.docx?sfvrsn=2

Kobau, R., Seligman, M. E. P., Peterson, C., Diener, E., Zack, M. M., Chapman, D., & Thompson, W. (2011). Mental health promotion in public health: Perspectives and strategies from positive psychology. *American Journal of Public Health*, 101, e1–e9. doi:10.2105/AJPH.2010.300083

Kress, V. E., Hoffman, R. M., Adamson, N., & Eriksen, K. (2013). Informed consent, confidentiality, and diagnosing: Ethical guidelines for counselor practice. *Journal of Mental Health Counseling*, *35*, 15–28.

Ladd, P. D. (2013). Knowledge vs. wisdom in *DSM* diagnosis: A person-centered perspective. In *Ideas and research you*

can use: VISTAS 2013. Retrieved from http://www.counselingoutfitters.com/vistas/vistas13/Article_6.pdf

Maddux, J. E. (2002). Stopping the "madness": Positive psychology and the deconstruction of the illness ideology and the *DSM*. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of Positive Psychology* (pp.13–25). New York, NY: Oxford University Press.

Magyar-Moe, J. L. (2009). *Therapist's guide to positive psychological interventions*. San Diego, CA: Elsevier Academic Press.

Mannarino, M. B., Loughran, M. J., & Hamilton, D. (2007, October). *The professional counselor and the diagnostic process: Challenges and opportunities for education and training*. Paper based on a program presented at the conference of the Association for Counselor Education and Supervision, Columbus, OH.

McAuliffe, G. J., & Eriksen, K. P. (1999). Toward a constructivist and developmental identity for the counseling profession: The context-phase-stage-style model. *Journal of Counseling & Development*, *77*, 267–280. doi:10.1002/j.1556-6676.1999.tb02450.x

Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development*, *89*, 140–147. doi:10.1002/j.1556-6678.2011.tb00071.x

Miller, R., & Prosek, E. A. (2013). Trends and implications of proposed changes to the *DSM-5* for vulnerable populations. *Journal of Counseling & Development*, *91*, 359–366. doi:10.1002/j.1556-6676.2013.00106.x

Moss, J. M., Gibson, D. M., & Dollarhide, C. T. (2014). Professional identity development: A grounded theory of transformational tasks of counselors. *Journal of Counseling & Development*, *92*, 3–12. doi:10.1002/j.1556-6676.2014.00124.x

Nemeroff, C. B., Weinberger, D., Rutter, M., MacMillan, H. L., Bryant, R. A., Wessely, S., . . . Lysaker, P. (2013). DSM-5: A collection of psychiatrist views on the changes, controversies, and future directions. *BMC Medicine*, *11*, 1–19. doi:10.1186/1741-7015-11-202

O'Hanlon, B., & Bertolino, B. (2012). *The therapist's notebook on positive psychology: Activities, exercises, and handouts*. New York, NY: Routledge.

Pedersen, P. (1987). Ten frequent assumptions of cultural bias in counseling. *Journal of Multicultural Counseling and Development*, *15*, 16–24.

Pedersen, P. B. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling & Development*, *70*, 6–12. doi:10.1002/j.1556-6676.1991.tb01555.x

Pedersen, P. B. (2003). Culturally biased assumptions in counseling psychology. *The Counseling Psychologist*, *31*, 396–403. doi:10.1177/0011000003031004002

Peterson, C. (2013). The strengths revolution: A positive psychology perspective. *Reclaiming Children and Youth*, *21*, 7–14.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. New York, NY: Oxford University Press and Washington, DC: American Psychological Association.

Pomeroy, E. C., & Anderson, K. (2013). The DSM-5 has arrived. *Social Work*, *58*, 197–200. doi:10.1093/sw/swt028

Rashid, T., & Anjum, A. (2008). Positive psychotherapy for young adults and children. In J. R. Z. Abela & B. L. Hankin (Eds.), *Handbook of depression in children and adolescents* (pp. 250–287). New York, NY: Guilford Press.

Remley, T. P., Jr., & Herlihy, B. P. (2014). *Ethical, legal, and professional issues in counseling* (4th ed.). Upper Saddle River, NJ: Pearson.

Seligman, M. E. P, Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist*, *61*, 774–788. doi:10.1037/0003-066X.61.8.774

Snyder, C. R., Lopez, S. J., Edwards, L. M., Pedrotti, J. T., Prosser, E. C., Walton, S. L., . . . Ulven, J. C. (2003). Measuring and labeling the positive and the negative. In S. J. Lopez & C. R. Snyder (Eds.), *Positive psychological assessment: A handbook of models and measures* (pp. 21–39). Washington, DC: American Psychological Association.

Society of Counseling Psychology, American Psychological Association, Division 17. (2014). *What is Counseling Psychology*. Retrieved from http://www.div17.org/about/what-is-counseling-psychology/

Sue, D. W., Arredondo, P., & McDavis, R. J. (l992). Multicultural competencies and standards: A call to the profession. *Journal of Counseling & Development*, *70*, 477–486. doi:10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., Bernier, J. E., Durran, A., Feinberg, L., Pedersen, P., Smith E. J., & Vasquez-Nuttall, E. (1982). Position paper: Cross-cultural counseling competencies. *The Counseling Psychologist*, *10*, 45–52.

doi:10.1177/0011000082102008

Sue, D. W., & Sue, D. (2013). *Counseling the culturally diverse: Theory and practice* (6th ed.). New York, NY: Wiley & Sons.

Sue, D., Sue, D. W., Sue, D., & Sue, S. (2014). *Essentials of understanding abnormal behavior* (2nd ed.). Belmont, CA: Cengage Learning.

Swartz-Kulstad, J. L., & Martin, W. E. (1999). Impact of culture and context on psychosocial adaptation: The cultural and contextual guide process. *Journal of Counseling & Development*, *77*, 281–293. doi:10.1002/j.1556-6676.1999.tb02451.x

Washburn, M. (2013). Five things social workers should know about the DSM-5. *Social Work*, *58*, 373–376. doi:10.1093/sw/swt030

Whiteley, J. M. (1984). A historical perspective on the development of counseling psychology as a profession. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (pp. 3–55). New York, NY: Wiley and Sons.

Wood, A. M., Linley, P. A., Maltby, J., Kashdan, T. B., & Hurling, R. (2011). Using personal and psychological strengths leads to increases in well-being over time: A longitudinal study and the development of the strengths use questionnaire. *Personality and Individual Differences*, *50*, 15–19. doi:10.1016/j.paid.2010.08.004

World Health Organization. (1979). *International statistical classification of diseases and related health problems, clinical modification* (9th rev.). Geneva, Switzerland: Author.

World Health Organization. (1992). *International statistical classification of diseases and related health problems* (10th rev.). Geneva, Switzerland: Author.

Wright, B. A., & Lopez, S. J. (2002). Widening the diagnostic focus: A case for including human strengths and environmental resources. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of Positive Psychology* (pp. 26–44). New York, NY: Oxford University Press.

DSM, Psychotherapy, Counseling and the Medicalization of Mental Illness: A Commentary from Allen Frances

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Allen Frances

Let us start with two important disclaimers. First, I will be identifying the many ways that the *Diagnostic and statistical manual of mental disorders* (*DSM*) system has been detrimental to psychotherapy and how the fifth edition (*DSM-5*; American Psychiatric Association [APA], 2013) will make the current situation even worse. However, this does not mean that I consider *DSM* diagnosis irrelevant to psychotherapy and counseling, nor do I believe that psychotherapists and counselors should neglect learning about diagnosis. I do not trust therapists who focus their contact with the client exclusively around the *DSM* diagnosis. Hippocrates believed that it is more important to know the person who has the disease than the disease the person has. Nevertheless, I also do not trust therapists who are completely free-form, impressionistic and idiosyncratic in their approach to clients. *DSM* diagnosis is only a small part of what goes into therapy, but it is often a crucial part. We need to know what makes each person different and unique; on the other hand, we also need to group clients with similar problems as a way of choosing interventions and predicting the treatment course.

The second disclaimer relates to the proper roles of medication, psychotherapy and counseling. The *DSM* has promoted a reductionistic medicalization of mental illness that, in combination with misleading drug company marketing strategies, has created a strong bias toward treatment with medication and against treatment with psychotherapy and counseling. I am greatly disturbed by the resulting enormous overuse of psychotropic drugs among both adults and children, many of whom do not need psychotropic drugs and would do much better without them. However, we must be equally alert to the fact that many people who need medication do not receive it. Psychotherapists and counselors are important gatekeepers who should recognize when medication is needed and when it is not. It makes no sense to be for or against medicating clients. It is crucial that medication not be used carelessly, but also essential to realize that it is sometimes absolutely necessary.

I will offer a brief history. Before the publication of the *DSM-III* (APA) in 1980, psychiatric diagnosis was a subject of little interest or importance because it was unreliable and not particularly useful for treatment planning. The *DSM-III* marked a sudden and dramatic change—it made diagnosis a major focus of clinical attention and the starting point of all treatment guidelines. Its provision of clearly defined criteria allowed for reasonably reliable diagnosis and for targeting specific symptoms that became the focus of treatment. The *DSM-III*'s influence exceeded all expectations, in some ways useful, but also with a significant defect. The prevailing mental health approach before the *DSM-III* was the well-rounded biopsychosocial model. At that time, clinicians conceptualized symptoms as arising from the complex interplay of brain functioning, psychological factors, and familial and social contexts. Perhaps without intention, the *DSM-III* downgraded the psychological and social factors and promoted undue emphasis on the biological factors. The *DSM-III* was advertised as "atheoretical" and neutral, usable by practitioners of all professional orientations. To some small degree, this

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was true; yet the *DSM-III*'s emphasis on purely descriptive psychiatry strongly favored biological treatments over cognitive-behavioral treatments. This bias proved to be irrelevant and eventually destructive to family and psychodynamic therapies. The descriptive *DSM-III* method focused attention on surface symptoms in the individual and ignored both deeper psychological understanding and the social and familial contexts. Clinicians often adopted a symptom checklist approach to evaluation and forgot that a complete evaluation must account for psychological factors, social supports and stressors.

In addition to its considerable impact on the mental health profession, the *DSM-III* also significantly affected the pharmaceutical industry. Drug companies benefited greatly from the *DSM-III* approach, particularly since 1987 when Prozac established the template for promoting blockbuster psychiatric drugs. Pharma realized that the best way to sell pills is to promote disease-mongering. Their marketing campaign offers the misleading idea that mental disorders are underdiagnosed, easy to diagnose due to chemical imbalances in the brain and best treated with a pill. The marketing targeted psychiatrists first, then primary care physicians and, since 1997, the general public. In the United States and New Zealand, drug companies have successfully bullied the government into allowing direct advertising to consumers on television, in print and on the Internet. Use of medication has skyrocketed as a result of these billion-dollar marketing budgets, turning us into a pill-popping society. This increase in drug use is great for Pharma shareholders and executives, but often inappropriate for clients and terribly costly to the economy. More than $40 billion a year are spent on psychiatric drugs. Most of these (80%) are prescribed by primary care doctors with little training or interest in psychiatric diagnosis or treatment, while under strong pressure from patients and drug company representatives, and after only seven minutes of evaluation on average. During the last decade, many drug companies have received enormous fines (e.g., one fine was $3.3 billion) for illegal marketing practices, but they continue because the rewards are so great.

For mild to moderate psychiatric problems, psychotherapy and counseling are just as effective as medication, and their effects are much more enduring. Most people taking medication would probably have been better off had they received psychotherapy or counseling. Unfortunately, psychotherapy and counseling suffer from two great disadvantages in their competition with drug treatment. Drug companies are enormously profitable industrial giants with billion-dollar budgets to push their products. In contrast, the mental health field is more of a nickel-and-dime, mom-and-pop operation with absolutely no marketing punch. Insurance companies further tilt the playing field by consistently favoring medication management over psychotherapy and counseling based on the mistaken assumption that it will be cheaper. In fact, brief treatments are often much more cost-effective because their effects are lasting, whereas medication may be necessary for years or a lifetime.

The medicalization of mental illness has had a dire impact on our clients and our society. Twenty percent of the population regularly takes a psychiatric drug, many for problems of everyday life more amenable to watchful waiting or psychotherapy and counseling than to drug treatment. It is astounding that there are now more overdoses and deaths from prescription drugs than street drugs. The tremendous societal investment in psychiatric drugs also misallocates resources much better spent on terribly underfunded social investments. Would it not be better for children to have smaller classes and more gym periods than for so many of them to be on pills for ADHD?

In preparing the *DSM-IV* (APA, 1994), we attempted to hold the line against diagnostic inflation and the medicalization of normality; however, we failed. During the past 20 years, the United States has experienced fad epidemics of ADHD, autism and bipolar disorder. We were conservative in writing the *DSM-IV*, but failed to anticipate or prevent its careless misuse under external pressure, particularly drug company marketing and the requirement of a psychiatric diagnosis for clients to qualify for school services and disability benefits. The quick fix is to give a diagnosis, but often this does more harm than good in the long run. Inaccurate diagnoses are easy

to give but hard to remove. Often they haunt the client for life with stigma, unnecessary treatments and reduced expectations. Making an accurate diagnosis requires really knowing one's client, which may take weeks or even months. In uncertain situations, it is better to underdiagnose than overdiagnose a symptom pattern, and better to be safe than sorry.

The *DSM-5* will considerably increase medicalization and may turn our current diagnostic inflation into hyperinflation. Overdiagnosis transforms normal grief into major depressive disorder, normal temper tantrums into disruptive mood dysregulation disorder, normal forgetfulness of old age into minor neurocognitive disorder, poor eating habits into binge eating disorder, and expectable worry about physical symptoms into somatic symptom disorder. It also further loosens the already far too slack criteria for attention deficit disorder and contains a completely confusing definition of autism. Experience teaches that whenever the diagnostic spigot is unrestricted, drug company revenues increase, and less funding is available to support psychotherapy and counseling visits.

The *DSM* is only one guide to diagnosis—it is not a bible or official manual of diagnosis. The *DSM* codes that clinicians routinely use for reimbursement are in fact all International Classification of Diseases, Clinical Modification (*ICD-CM*) codes that are available for free on the Internet. *DSM-5* is one suggested way to arrive at an *ICD-CM* diagnosis, but it is not the only or best way. Other more reliable guides to psychiatric diagnosis are available. Therapists do not have to buy or use the *DSM-5* unless they work for an institution that requires it.

Receiving a psychiatric diagnosis can be a turning point in a client's life. An accurate diagnosis can lead to an effective treatment plan; an inaccurate diagnosis can lead to side effects, stigma, high costs, reduced opportunities and needless suffering. Severe and classic presentations require quick diagnosis and immediate intervention, usually including medication. Milder, equivocal presentations allow for and require a more cautious approach. Therefore, watchful waiting or brief counseling is usually best.

Conflict of Interest and Funding Disclosure
The author published two books that critically review the DSM-5*, titled* Saving Normal *and* Essentials of Psychiatric Diagnosis*.*

References

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

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