

Volume 4, Issue 3

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

The Professional Counselor
DIGEST



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Special Issue: Counseling and the *DSM-5*

Dr. Matthew R. Buckley, Guest Editor

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

Matthew R. Buckley

A U T H O R S

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The American Psychiatric Association recently published the fifth edition of the *Diagnostic and Statistical Manual for Mental Disorders (DSM-5)* as a revision of a foundational diagnostic tool designed to help professionals within a wide variety of mental health disciplines assess, conceptualize and plan for treatment on behalf of people who suffer mental distress. The *DSM* system facilitates a common understanding in a common language of complex and entrenched symptomology, and this current version of the *DSM* was designed to align with the current version of the *International Statistical Classification of Diseases and Related Health Problems (ICD-9)*. Political, social, legal and cultural dynamics influenced the *DSM-5*'s development, which was not without controversy. As with any tool, concerns have emerged about the potential of its unintended misuse. It is the responsibility of mental health counselors and other professionals to prevent misapplication of the manual and to use it ethically.

This article provides a reminder of important tasks for mental health professionals to incorporate into the process of diagnosis, tasks which constitute getting “back to the basics” of sound clinical practice. These steps related to assessment and diagnosis include considering the following: to what extent clients may intentionally produce signs and symptoms; 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. Additionally, it is important to take culture into consideration when working with clients in a clinical setting. The new Cultural Formulation Interview (CFI) is one of over 60 cross-cutting symptom and severity measures included on the *DSM-5* website (see <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures>), and was developed

to promote intentional assessment of how cultural differences between client and clinician may impact help seeking and treatment planning. Assessment instruments designed for the *DSM-5* and a companion website dedicated to this edition are new features of the *DSM-5*.

In addition, the article introduces this special issue of *The Professional Counselor*, which is focused on the *DSM-5* and covers a variety of foundational topics including the historical roots of this complex nosology, changes within the *DSM-5* that impact clinical practice, how the *DSM* has evolved over time, the deletion of the multiaxial system, the harmonization of the *DSM-5* with the *ICD*, the inclusion of cross-cutting symptom measures and dimensional assessments, and the organization of the manual. Specific topics include applying the *DSM-5* to clinical practice, a review of how cross-cutting symptom and severity measures meet the standard of psychometric instrumentation, how chronic and persistent mental illness is conceptualized, changes in feeding and eating disorders, and the treatment of trauma- and stressor-related disorders. Readers will find the articles in this special issue a good primer as they prepare to understand and use the *DSM-5* in clinical practice.

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

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Regardless of background, training or theoretical orientation, professional counselors must have a thorough understanding of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, published by the American Psychiatric Association in 2013. The purpose of this article is to review major structural and philosophical changes from the *DSM-IV-TR* to the *DSM-5* and to explain the implications that these changes may have on professional counselors and diagnostic practice. To accomplish this, the authors begin with a review of the development of the *DSM* and an overview of the 13-year revision process that began after the publication of the *DSM-IV-TR* and resulted in the *DSM-5*.

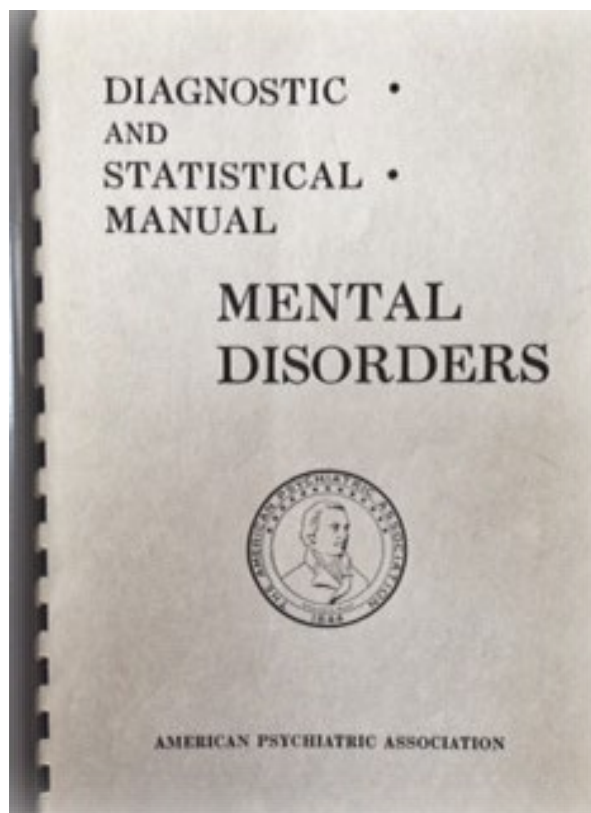
Having described different iterations of the *DSM*, from its first edition to the *DSM-IV-TR*, the authors summarize psychiatry's attempts to standardize mental illness classification. The authors give a historical overview of the many versions of the *DSM* and their progression from a purely descriptive approach of mental disorders to rigid classification systems. In a review of the most current revision process, the authors highlight the *DSM-5* Task Force's goal of eradicating the use of *not otherwise specified* (NOS) diagnoses, to eliminate functional impairment as a necessary component of diagnostic criteria, and to use empirically based evidence to justify diagnostic classes and specifiers.

DSM ⇨ DSM-5

Following the historical review, the authors address the major structural changes from the *DSM-IV-TR* to the *DSM-5*. The authors highlight the division of the *DSM* into three separate sections, as well as the revised chapter organization, which includes significant modifications to diagnostic classifications, such as the separation of anxiety disorders into three distinct chapters. Other structural modifications involve the inclusion of cross-cutting symptom and severity measures and the World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0); the adoption of a uniaxial system; and more coverage of cultural formulations of diagnosis than any other *DSM* version to date.

The authors also cover two major philosophical changes in the *DSM*. The first involves movement away from the medical model toward a biological model. The second is a subtle shift away from a strictly categorical (i.e., checklist) classification system to the inclusion of a dimensional approach to nosology. The authors conclude with a summary of practice implications for counselors, including specific guidance for coding, recording, and use of specifiers; information regarding emerging measures; and implications of the *DSM-5* for both counselors and clients.

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

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The *International Classification of Diseases (ICD)* and the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* are the two dominant tools for classifying mental disorders. While they have similarities, there are also important differences that have led to difficulty communicating across the two systems. From the outset of the *DSM-5* development, there has been an effort to harmonize differences between the two manuals. A major innovation of *DSM-5* is that it jettisons the multi-axial system in favor of the non-axial system that *ICD-10* uses. Further, the forthcoming *ICD-*

11 will adopt the organizational structure and chapter names of the *DSM-5*. One potential shortcoming of this harmonization effort is that diagnostic information is lost in abandoning the multi-axial system. In addition, consilience with the *ICD* further medicalizes the *DSM*.

A second conceptual innovation of the *DSM-5* is the introduction of spectrum disorders and dimensional ratings. Spectrum disorders combine highly overlapping disorders into a single disorder and use a dimensional rating of severity to indicate the individual's place on the spectrum. Dimensional rating scales are also being introduced to augment the clinical assessment. Concerns include the calibration of the spectrum rating and the psychometric properties of the proposed dimensional measures.

A third conceptual innovation is the new organization of the manual's mental disorders.

Spectrum Disorders

Unlike earlier manuals, the *DSM-5* draws upon empirical data to cluster disorders. The new organization also introduces a lifespan perspective in ordering disorders within chapters and across the manual. However, it will be challenging for mental health counselors to learn this unfamiliar organization.

These three conceptual innovations define the new look of the *DSM-5*. The benefits include enhancing the diagnostic enterprise and furthering understanding of the nature of mental disorders. The risk, however, is that the new edition further medicalizes the manual at the expense of a more biopsychosocial assessment.

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

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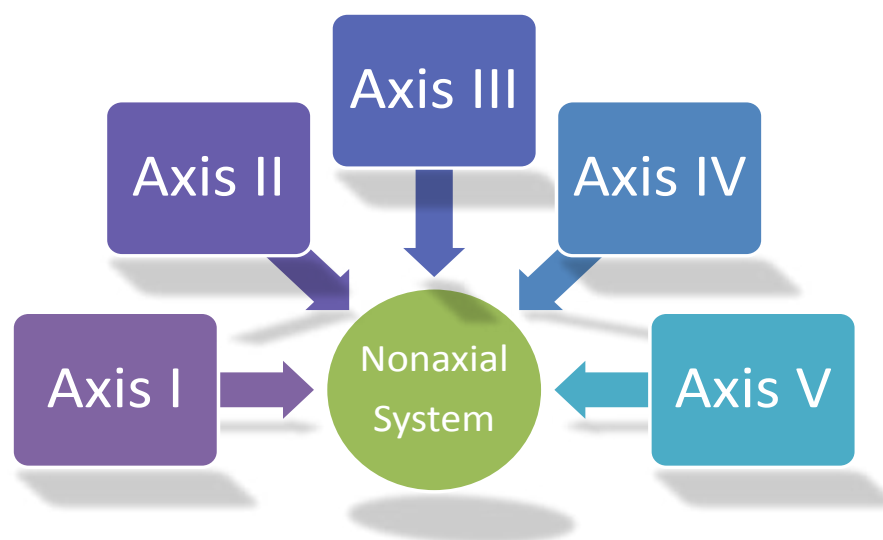
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The release of the *DSM-5* has brought about many changes in the field of mental health. Arguably one of the most significant changes in this latest edition of the *DSM* is the removal of the multiaxial system. This change has implications for the way that counselors diagnose and conceptualize clients' cases. The authors of this article provide practice suggestions specific to the removal of each axis in order to assist counselors in adjusting to the new diagnostic system.

In the past, counselors have had to consider several factors in adapting the *DSM* system to fit within their counseling practice. Philosophical differences between the *DSM*, which relies upon the medical model, and

the field of counseling, which promotes a developmental and wellness model, have had to be reconciled. In the *DSM-5*, Axes I, II and III have been eliminated, and any disorders previously coded on these three Axes are now listed together. This change suggests that there is no differentiation between medical and mental health conditions and disorders. While this may reduce stigma by comparing mental disorders to medical disorders, it also may reinforce the concept that people diagnosed with a mental disorder are biologically flawed.

The removal of the multiaxial system presents other issues in fully conceptualizing contextual factors and their roles in clients' presenting issues. Axis IV was helpful in



acknowledging contextual factors, which many counselors argue is critically important in fully understanding clients' situations. Without the multi-axial diagnostic system, counselors' thoroughness relative to context may suffer. The authors of this article encourage counselors to continue to emphasize contextual factors and complete thorough assessments despite the removal of the multi-axial system. Counselors should be aware that the *DSM* diagnostic process is only one part of a comprehensive assessment, and any thorough assessment must consider all relevant factors. The *DSM-5* also provides additional assessment measures, such as the *WHODAS 2.0* to assess overall functioning and the CFI to assess for cultural and contextual factors.

While the removal of the multi-axial system may present paradigm shifts in case conceptualization, it provides an opportunity for counselors to reaffirm a holistic and integrated view of clients and to provide leadership to the other mental health professions and professionals on how to incorporate this perspective into diagnostic practices.

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

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* continues a 60-year legacy as a standard reference for clinical practice in the mental health field. The *DSM-5* represents 12 years of culminating work among hundreds of medical and mental health professionals. The manual was revised in such a manner as to stimulate new clinical perspectives, promote a new generation of research into the biological markers of mental health disorders, and facilitate more reliable diagnoses of the disorders.

The American Psychiatric Association (APA) describes the *DSM-5* as a “practical, functional, and flexible guide” for trained counselors’ use in a wide diversity of contexts, a guide that facilitates a common language to communicate the essential characteristics of mental disorders manifested in their clients. As counselors dive into the new manual, they will notice an expanded discussion

of a dimensional approach to diagnosis; developmental and lifespan considerations; cultural issues; gender differences; appropriate use of other specified and unspecified disorders; integration of scientific findings from the latest research in genetics and neuroimaging; the multiaxial systems; online enhancements; and enhanced use of course, descriptive and severity specifiers for diagnostic precision. They will also notice consolidation, streamlining and restructuring of most mental disorders so as to promote clinical utility and advanced clinical case formulation. In addition, counselors will learn about a new definition of a mental disorder, new elements of a diagnosis and emerging assessments and monitoring tools.

This article is intended to assist all counselor specialties, especially counselors who embrace the professional identity of the CACREP clinical mental health counseling specialty. The author reviews six mental health



disorders with a focus on changes between the *DSM-IV-TR* (APA, 2000) and the *DSM-5* that represent the new landscape for each of these disorders, respectively. Following the summary of changes, the author presents a clinical scenario so that counselors can capture the vision of using the *DSM-5* in real-time clinical practice. In particular, the author discusses autism spectrum disorder; schizophrenia and other psychotic disorders; excoriation (skin-picking) disorder; post-traumatic stress disorder; sleep-wake disorders and neurocognitive disorders. The author also presents clinical formulation (sample diagnosis) using the *DSM-5* for each disorder classification. The article concludes by summarizing the clinical utility of the *DSM-5* and providing recommendations for counselors on how to effectively sequence their study of the new manual.

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

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The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* includes a section titled “Emerging Measures and Models,” which contains “tools and techniques to enhance the clinical decision-making process, understand the cultural context of mental disorders, and recognize emerging diagnoses for further study.” At the forefront of this section, the American Psychiatric Association introduced *cross-cutting symptom measures (CCSMs)* that include two levels. Level 1 is concise, containing 1–4 items in each domain; whereas Level 2 is more comprehensive, offering a measure for each domain. 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 ask how often the individual has been bothered by the symptom within

a time period of 7 days, and others ask the individual to choose a statement in a cluster that best represents the way he or she has felt within those 7 days. Common psychometric properties, such as the reporting of reliability estimates of the scores, were not readily



Cross-Cutting Symptom Measures

DSM-5 Diagnostic Criteria



apparent, if published at all. Standards related to the alignment of the instruments with the *DSM* symptoms (i.e., evidence based on test content) were circumspect.

Overall, compared to the emotional and behavioral symptoms included in the *DSM-5* diagnoses, these Level 2 measures lack many crucial criteria, thereby inadequately addressing validity evidence based on test content. The Level 2 measures are fairly short and simple, containing few items. This dearth of criteria shows a lack of consistency when compared to specific symptoms within a diagnosis.

Given the influence of the *DSM* system of diagnosis (e.g., in reimbursement, research studies, treatment planning), the publication of emerging measures that fail to meet basic

standards of testing and measurement is disconcerting. Perhaps the most basic critique of the system is that the measures publication in the *DSM-5* lack alignment to the very diagnostic categories they are supposed to evaluate. The presence of these emerging measures in the *DSM-5* presents an incomplete system that fails to comprehensively augment the categorical system of diagnosis that the American Psychiatric Association currently endorses. In this case, publication of dimensional measures may have been premature. Professional counselors should be cautious in the adaptation of these emerging measures at this time.

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

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Major depressive disorder, bipolar I disorder and schizophrenia are chronic mental health conditions. Adults with these diagnoses often benefit from mental health treatment throughout their lives. The recent revisions to the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, culminating in the 2013 publication of the *DSM-5*, included changes to these three disorders. The authors of this article provide the cases of Martha, Bo and Saul, in which readers can see the implications of the *DSM* changes for clients who are already in treatment.

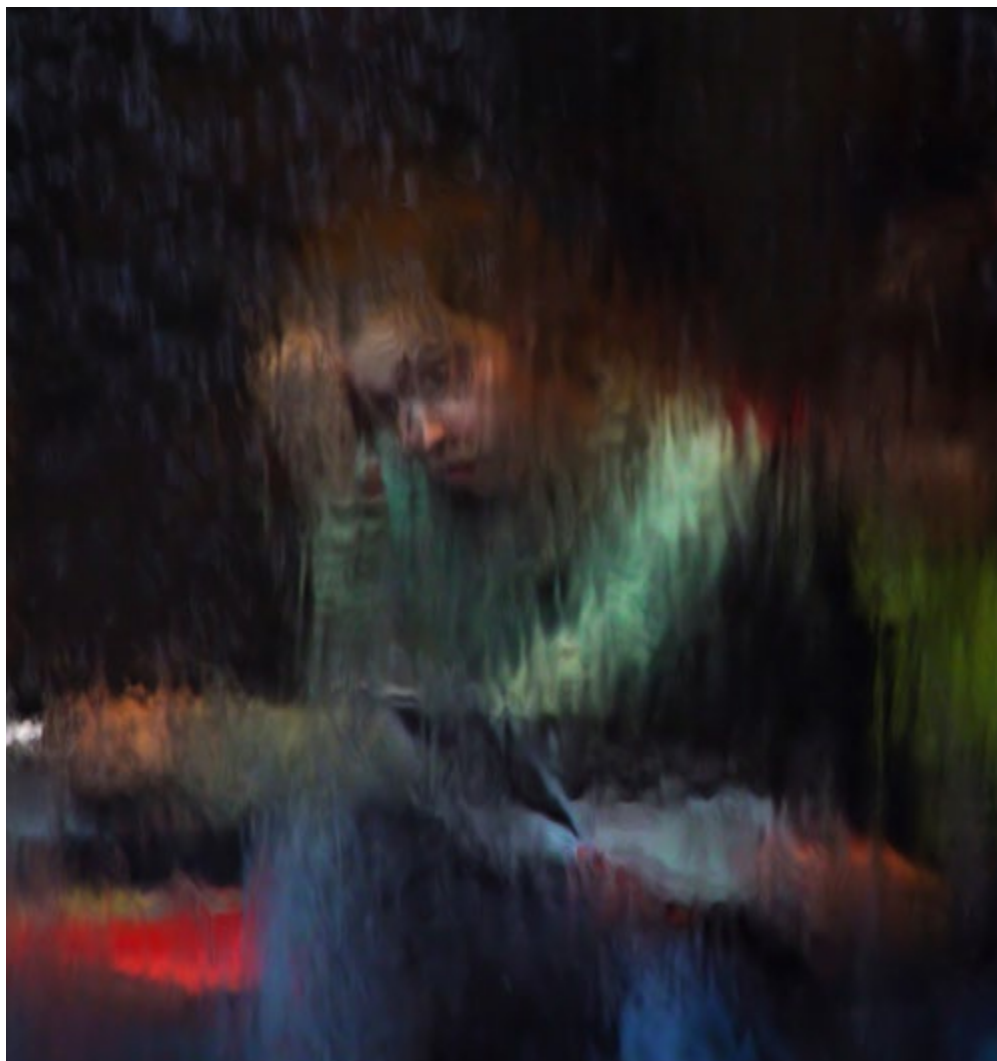
Revisions to major depressive disorder included added descriptors for some symptoms so that clinicians can consistently determine whether criteria are met. In order to emphasize the importance of key symptoms, new specifiers related to anxious distress and mixed

features were added. Clients who have anxiety or mixed features in addition to depression often require different treatment strategies, so including this information in the diagnosis may improve treatment efficacy. Revisions to bipolar I disorder also improved clarity by adding rules for frequency and severity of symptoms required for diagnosis. An important exclusion criterion was removed as well. Previously, manic or hypomanic symptoms following antidepressant treatment were not sufficient for a bipolar diagnosis. In *DSM-5*, those symptoms do count toward a diagnosis of bipolar disorder, and a practitioner can make the diagnosis if the client meets full criteria for the disorder. Finally, schizophrenia was revised to increase the diagnostic threshold by requiring at least two core symptoms, one of which must be hallucinations, delusions or disorganized speech. The subtypes (e.g., schizophrenia, paranoid type) were removed,

and a new severity scale was added that allows clinicians to better note levels of client functioning.

These changes and others require counselors to update their diagnostic practices. With the release of the *DSM-5*, counselors have an opportunity to help clients understand the changes and develop an accurate, healthy understanding of their condition. By using thorough, updated notation in medical records and insurance documentation, counselors can communicate effectively using

the common language established by the *DSM-5* and enable sophisticated research on trends in diagnosis and treatment. Counselors, supervisors and counselor educators may find these cases helpful as they revise their diagnostic practices.



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

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The publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* brought changes to the diagnostic system, structure and specific criteria of many eating and feeding disorders. A major change is the placement of all eating and feeding disorders in their own chapter, “Feeding and Eating Disorders,” which now allows for the diagnosis of all of these disorders at any age. This chapter marks a change from the *DSM-IV-TR*, which separated disorders that were usually first diagnosed in infancy, childhood and adolescence from those that emerged later in life.

The diagnostic criteria for pica and rumination disorder, which primarily occur in children with developmental disabilities, remain relatively unchanged in the *DSM-5*. The only revision is their placement in the

newly formed chapter for eating and feeding disorders. The diagnostic criteria for anorexia nervosa and bulimia nervosa underwent minor modifications. Anorexia nervosa no longer requires amenorrhea, thus making the diagnosis more gender-inclusive. Bulimia nervosa experienced one modification, which was the reduction of the minimum required frequency of bingeing and compensatory behavior, a change that will likely make this diagnosis applicable to a wider range of individuals.

In addition, the *DSM-5* no longer includes *eating disorder not otherwise specified*, and has replaced this diagnosis with two new options. Two new eating and feeding disorders in the *DSM-5* include avoidant/restrictive food intake disorder and binge-eating disorder. The former, while new, closely resembles feeding disorder of infancy or early childhood, which

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

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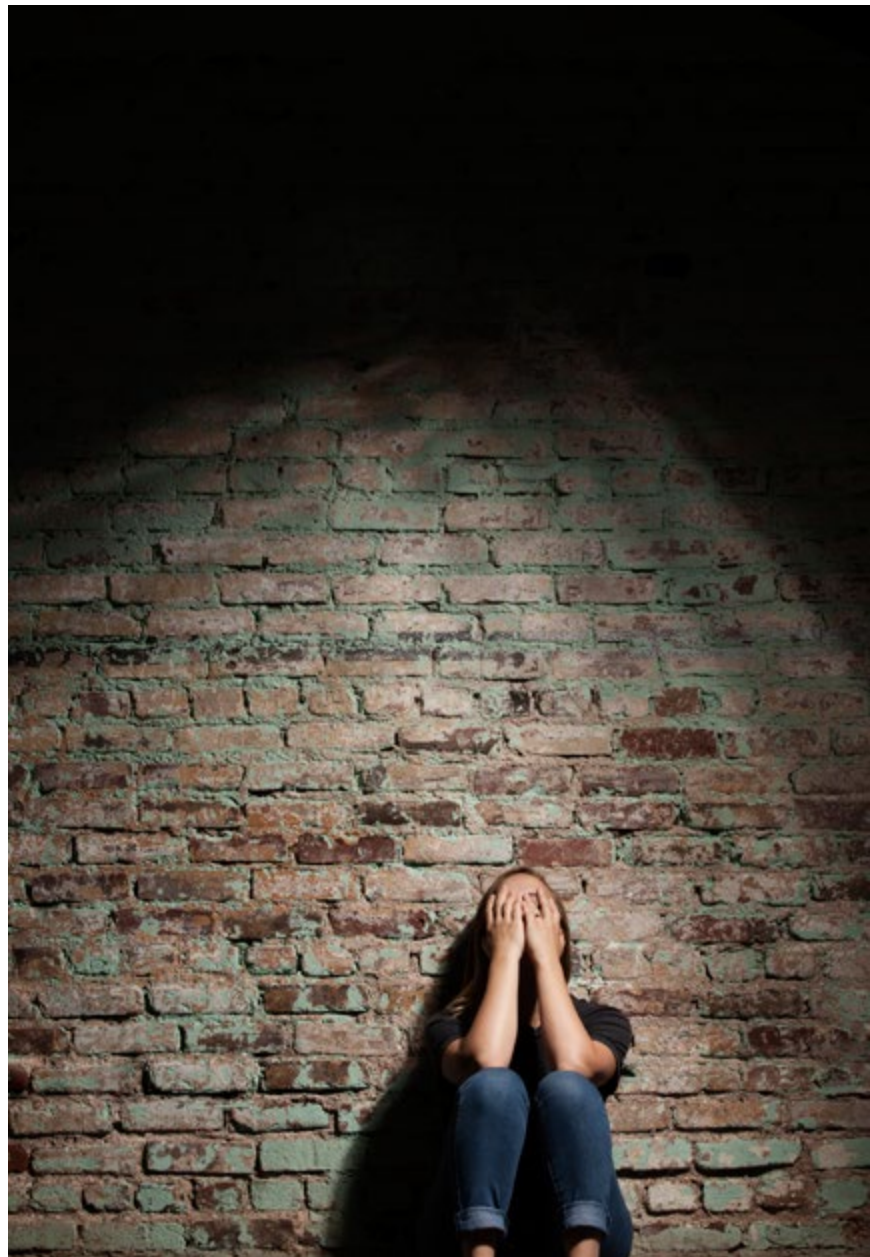
Nearly 80% of clients seen in community mental health clinics have experienced at least one incident of trauma during their lifetime, representing roughly five out of every six clients. Over the past 15 years, between increases in school and community violence in the United States and unrelenting wars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

Survivors of trauma are a unique population of clients whose treatment requires specialized knowledge and multifaceted considerations from counselors. Furthermore, nearly three-quarters of practicing therapists report wanting additional support and education for their

trauma work. Authors and 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. The highly debated and variable definition of trauma and related PTSD diagnostic criteria may contribute to low counselor efficacy in trauma practice.

The *DSM-5* contains substantial changes from the *DSM-IV-TR*, including the addition of *Trauma- and Stressor-related Disorders*, a new category distinct from *Anxiety Disorders*; the restructuring of PTSD diagnostic criteria; the modification of PTSD symptoms and specifiers; and the addition of a new subtype of PTSD in children. Without a clear understanding of the requirements

for trauma diagnoses in the *DSM-5*, counselors may feel tentative about assessing for trauma and selecting appropriate interventions. Understanding these changes and the rationale behind them is essential to thorough client conceptualization and efficacious counseling. This manuscript explores the changing definitions of trauma over time, the implications of such changes on counseling practice, and areas needing growth and research. While the article's core focus is on PTSD, the authors briefly discuss other trauma- and stress-related disorders. By outlining the *DSM-5* changes, reviewing recent research substantiating such modifications and providing practical suggestions for practitioners, the authors hope to mitigate confusion and enhance efficacy in counselors working with trauma clients during this crucial transition impacting the counseling field.



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DSM-5: A Commentary on Integrating Multicultural and Strength-Based Considerations into Counseling Training and Practice – DIGEST

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With a focus on helping people to resolve problems, the counseling profession has maintained an emphasis on growth, prevention and early intervention across the lifespan. With the publication of the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, issues related to the appropriateness of 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.

In promoting counselor professional identity and reinforcing the consensus definition of professional counseling as empowering individuals, families and groups, teaching diagnosis and the *DSM-*

5 to counseling trainees requires a contextual understanding of people and their concerns. Providing counseling trainees with the learning experiences designed to foster knowledge and skills extends beyond exposure to the *DSM-5* classification systems for categorizing behavior as disordered. Successfully integrating knowledge, skills, diagnostic practices and the *DSM-5* into counselor





education involves a review of the counseling profession's core curricular and professional practices, a review of the *DSM-5*, and an examination of beliefs and assumptions about people and models of helping that support learning and change.

Important considerations for teaching the *DSM-5* are directly related to understanding the diagnostic process and implications for models of helping used to conceptualize counseling goals and interventions with clients. Teaching the *DSM-5* to counseling students in a way that is consistent with counseling theory and practice involves identifying a model of helping that is congruent with professional counseling identity. The integration of a strength-based framework and counselor preparation ensures a holistic approach to assessment and treatment.

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

Allen Frances

A U T H O R

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Let us start with two important disclaimers. First, I will be identifying the many ways that the *DSM* system has been detrimental to psychotherapy and how the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* will make the current situation even worse. However, *DSM* diagnosis is relevant to psychotherapy and counseling, and psychotherapists and counselors should learn about diagnosis. Hippocrates believed that it is more important to know the person who has the disease than the disease the person has. *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.

Second, the next 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. Psychotherapists and counselors are important gatekeepers who should recognize when medication is needed and when it is not. It is crucial that medication not be used carelessly, but also essential to realize that it is sometimes absolutely necessary.

Before the publication of *DSM-III* in 1980, psychiatric diagnosis was a subject of little interest or importance, because it was unreliable and not particularly useful for treatment planning. *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 prevailing mental health approach before *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. 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, *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. 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. Use of medication has skyrocketed as a result of these billion-dollar marketing budgets, turning us into a pill-popping society. More than \$40 billion a year are spent on psychiatric drugs. For mild to moderate psychiatric problems,

psychotherapy and counseling are just as effective as medication, and their effects are much more enduring. Insurance companies consistently favor 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.

In preparing the *DSM-IV*, we attempted to hold the line against diagnostic inflation and the medicalization of normality; however, we failed. During the past 20 years, the U.S. has experienced fad epidemics of ADHD, autism and bipolar disorder. Inaccurate diagnoses are easy to give, but they are hard to remove, often haunting clients for life with stigma, unnecessary treatments and reduced expectations. The *DSM-5* will considerably increase medicalization and may turn our current diagnostic inflation into hyperinflation. The *DSM* is only one guide to diagnosis—it is not a bible or an official manual of diagnosis. The *DSM* codes that clinicians routinely use for reimbursement are in fact all *ICD-CM* codes that are available for free on the Internet. Receiving a psychiatric diagnosis can be a turning point in a client's life. Therefore, watchful waiting or brief counseling is usually best.

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