

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 multi-axial classification system and the Global Assessment of Functioning (GAF) scale. Never required for diagnosis, the APA removed the multi-axial 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 amnesic 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 multi-axial 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 clinicians might dismiss important sociocultural variations, especially given the elimination of the multi-axial 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 dysthymia 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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