This book is dedicated to professional counselors who draw upon the art and science of counseling in a courageous attempt to serve and foster growth in those seeking relief, wellness, and personal empowerment.
# Table of Contents

<table>
<thead>
<tr>
<th>Foreword</th>
<th>xi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgments</td>
<td>xiii</td>
</tr>
<tr>
<td>About the Authors</td>
<td>xv</td>
</tr>
</tbody>
</table>

## Chapter 1

**Introduction and Overview**
- Counseling Identity and Diagnosis  
- Why We Wrote This *Learning Companion*  
- The Revision Process  
- Revision Feedback  
- Organization of the *DSM-5 Learning Companion for Counselors*  
- References

## Chapter 2

**Structural, Philosophical, and Major Diagnostic Changes**
- History of the *DSM*
- *DSM-5* Structural Changes  
- *DSM-5* Philosophical Changes  
- Major Diagnostic Highlights  
- Implications of the *DSM-5*  
- Future of the *DSM-5*: Where Will It Go From Here?  
- References

## Introduction to Diagnostic Changes

**Part One to Part Four Overview**

### Part One

Changes and Implications Involving Mood, Anxiety, and Stressor-Related Concerns

**Part One Introduction**

## Chapter 3

**Depressive Disorders**
- Major Changes From *DSM-IV-TR* to *DSM-5*  
- Differential Diagnosis
### Table of Contents

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Etiology and Treatment</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Implications for Counselors</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Disruptive Mood Dysregulation Disorder</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Major Depressive Disorder, Single Episode and Recurrent Episodes</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Persistent Depressive Disorder (Dysthymia)</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>Premenstrual Dysphoric Disorder</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Substance/Medication-Induced Depressive Disorder</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Depressive Disorder Due to Another Medical Condition</td>
<td>48</td>
</tr>
<tr>
<td></td>
<td>Other Specified and Unspecified Depressive Disorders</td>
<td>49</td>
</tr>
<tr>
<td></td>
<td>Specifiers for Depressive Disorders</td>
<td>49</td>
</tr>
<tr>
<td>Chapter 4</td>
<td>Bipolar and Related Disorders</td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>53</td>
</tr>
<tr>
<td></td>
<td>Differential Diagnosis</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Etiology and Treatment</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Implications for Counselors</td>
<td>54</td>
</tr>
<tr>
<td></td>
<td>Bipolar I Disorder</td>
<td>55</td>
</tr>
<tr>
<td></td>
<td>Bipolar II Disorder</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Cyclothymic Disorder</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Substance/Medication-Induced Bipolar and Related Disorder</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Bipolar and Related Disorder Due to Another Medical Condition</td>
<td>63</td>
</tr>
<tr>
<td></td>
<td>Other Specified and Unspecified Bipolar and Related Disorders</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>Specifiers for Bipolar and Related Disorders</td>
<td>65</td>
</tr>
<tr>
<td>Chapter 5</td>
<td>Anxiety Disorders</td>
<td>69</td>
</tr>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Differential Diagnosis</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Etiology and Treatment</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>Implications for Counselors</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Separation Anxiety Disorder</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Selective Mutism</td>
<td>73</td>
</tr>
<tr>
<td></td>
<td>Specific Phobia</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>Social Anxiety Disorder (Social Phobia)</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>Panic Disorder</td>
<td>78</td>
</tr>
<tr>
<td></td>
<td>Panic Attack Specifier</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>Agoraphobia</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>Generalized Anxiety Disorder</td>
<td>81</td>
</tr>
<tr>
<td></td>
<td>Substance/Medication-Induced Anxiety Disorder</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>Anxiety Disorder Due to Another Medical Condition</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>Other Specified and Unspecified Anxiety Disorders</td>
<td>85</td>
</tr>
<tr>
<td>Chapter 6</td>
<td>Obsessive-Compulsive and Related Disorders</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Differential Diagnosis</td>
<td>88</td>
</tr>
<tr>
<td></td>
<td>Etiology and Treatment</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Implications for Counselors</td>
<td>89</td>
</tr>
<tr>
<td></td>
<td>Obsessive-Compulsive Disorder</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>Body Dysmorphic Disorder</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>Hoarding Disorder</td>
<td>95</td>
</tr>
<tr>
<td></td>
<td>Trichotillomania (Hair-Pulling Disorder)</td>
<td>98</td>
</tr>
<tr>
<td></td>
<td>Excoriation (Skin-Picking) Disorder</td>
<td>99</td>
</tr>
<tr>
<td></td>
<td>Substance/Medication-Induced Obsessive-Compulsive and Related Disorder</td>
<td>101</td>
</tr>
<tr>
<td></td>
<td>Obsessive-Compulsive and Related Disorder Due to Another Medical Condition</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>Other Specified and Unspecified Obsessive-Compulsive and Related Disorders</td>
<td>104</td>
</tr>
<tr>
<td>Chapter 7:</td>
<td>Trauma- and Stressor-Related Disorders</td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>105</td>
</tr>
<tr>
<td></td>
<td>Essential Features</td>
<td>106</td>
</tr>
<tr>
<td>Chapter 8</td>
<td>Gender Dysphoria in Children, Adolescents, and Adults</td>
<td>125</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>Essential Features</td>
<td>128</td>
</tr>
<tr>
<td></td>
<td>Differential Diagnosis</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>Etiology and Treatment</td>
<td>131</td>
</tr>
<tr>
<td></td>
<td>Implications for Counselors</td>
<td>132</td>
</tr>
<tr>
<td></td>
<td>Coding, Recording, and Specifiers</td>
<td>133</td>
</tr>
</tbody>
</table>

**Part One References** 135

**Part Two**

Changes and Implications Involving Addictive, Impulse-Control, and Specific Behavior-Related Concerns

**Part Two Introduction** 147

<table>
<thead>
<tr>
<th>Chapter 9</th>
<th>Substance-Related and Addictive Disorders</th>
<th>149</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Substance-Related Disorders</td>
<td>151</td>
</tr>
<tr>
<td></td>
<td>Substance Intoxication and Withdrawal</td>
<td>153</td>
</tr>
<tr>
<td></td>
<td>Specific Substance-Related Disorders Overview</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>Gambling Disorder</td>
<td>161</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 10</th>
<th>Disruptive, Impulse-Control, and Conduct Disorders</th>
<th>165</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Major Changes From <em>DSM-IV-TR</em> to <em>DSM-5</em></td>
<td>166</td>
</tr>
<tr>
<td></td>
<td>Differential Diagnosis</td>
<td>167</td>
</tr>
<tr>
<td></td>
<td>Etiology and Treatment</td>
<td>168</td>
</tr>
<tr>
<td></td>
<td>Implications for Counselors</td>
<td>169</td>
</tr>
<tr>
<td></td>
<td>Oppositional Defiant Disorder</td>
<td>170</td>
</tr>
<tr>
<td></td>
<td>Intermittent Explosive Disorder</td>
<td>172</td>
</tr>
<tr>
<td></td>
<td>Conduct Disorder</td>
<td>173</td>
</tr>
<tr>
<td></td>
<td>Pyromania</td>
<td>175</td>
</tr>
<tr>
<td></td>
<td>Kleptomania</td>
<td>177</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chapter 11</th>
<th>Specific Behavioral Disruptions</th>
<th>179</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Feeding and Eating Disorders</td>
<td>179</td>
</tr>
<tr>
<td></td>
<td>Specific Feeding Disorders</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>Pica</td>
<td>184</td>
</tr>
<tr>
<td></td>
<td>Rumination Disorder</td>
<td>186</td>
</tr>
<tr>
<td></td>
<td>Avoidant/Restrictive Food Intake Disorder</td>
<td>187</td>
</tr>
<tr>
<td></td>
<td>Specific Eating Disorders</td>
<td>188</td>
</tr>
<tr>
<td></td>
<td>Anorexia Nervosa</td>
<td>188</td>
</tr>
<tr>
<td></td>
<td>Bulimia Nervosa</td>
<td>191</td>
</tr>
<tr>
<td></td>
<td>Binge-Eating Disorder</td>
<td>194</td>
</tr>
<tr>
<td></td>
<td>Elimination Disorders</td>
<td>196</td>
</tr>
<tr>
<td></td>
<td>Enuresis</td>
<td>197</td>
</tr>
<tr>
<td></td>
<td>Encopresis</td>
<td>199</td>
</tr>
</tbody>
</table>
### Table of Contents

Sleep-Wake Disorders 199  
Insomnia Disorder 200  
Hypersomnolence Disorder and Narcolepsy 201  
Breathing-Related Sleep Disorders 202  
Parasomnias 203  
Circadian Rhythm Sleep-Wake Disorders 204  
Restless Legs Syndrome 205  
Substance/Medication-Induced Sleep Disorder 205  
Additional Resources for Sleep Disorders 205  
Sexual Dysfunctions 205  
Delayed Ejaculation 208  
Erectile Disorder 209  
Female Orgasmic Disorder 210  
Female Sexual Interest/Arousal Disorder 211  
Genito-Pelvic Pain/Penetration Disorder 211  
Male Hypoactive Sexual Desire Disorder 212  
Premature (Early) Ejaculation 213  
Substance/Medication-Induced Sexual Dysfunction 214  
Paraphilic Disorders 214  
Pedophilic Disorder 216  
Exhibitionistic Disorder 218  
Voyeuristic Disorder 220  
Frotteuristic Disorder 220  
Sexual Masochism Disorder and Sexual Sadism Disorder 221  
Fetishistic Disorder 223  
Transvestic Disorder 223  

Part Two References 225

Part Three

### Changes and Implications Involving Diagnoses Commonly Made by Other Professionals

Part Three Introduction 235

Chapter 12  
**Neurodevelopmental and Neurocognitive Disorders** 239  
Neurodevelopmental Disorders 239  
Intellectual Disabilities 241  
Intellectual Disability (Intellectual Developmental Disorder) 242  
Global Developmental Delay 242  
Communication Disorders 242  
Language Disorder 243  
Speech Sound Disorder 243  
Childhood-Onset Fluency Disorder (Stuttering) 243  
Social (Pragmatic) Communication Disorder 244  
Autism Spectrum Disorder 244  
Attention-Deficit/Hyperactivity Disorder 247  
Specific Learning Disorder 249  
Motor Disorders 249  
Developmental Coordination Disorder 249  
Sterotytipic Movement Disorder 250  
Tic Disorders 250  
Neurocognitive Disorders 251  
Delirium 252  
Major Neurocognitive Disorder 253  
Mild Neurocognitive Disorder 254  
Major and Mild Neurocognitive Disorders 254
### Table of Contents

**Chapter 13**  
**Schizophrenia Spectrum and Other Psychotic Disorders**  
- Major Changes From *DSM-IV-TR* to *DSM-5*  
- Differential Diagnosis  
- Etiology and Treatment  
- Implications for Counselors  
- Delusional Disorder  
- Brief Psychotic Disorder  
- Schizophreniform Disorder  
- Schizophrenia  
- Schizoaffective Disorder  
- Substance/Medication-Induced Psychotic Disorder  
- Psychotic Disorder Due to Another Medical Condition  
- Catatonia  

**Chapter 14**  
**Dissociative Disorders**  
- Major Changes From *DSM-IV-TR* to *DSM-5*  
- Differential Diagnosis  
- Etiology and Treatment  
- Implications for Counselors  
- Dissociative Identity Disorder  
- Dissociative Amnesia  
- Depersonalization/Derealization Disorder  

**Chapter 15**  
**Somatic Symptom and Related Disorders**  
- Major Changes From *DSM-IV-TR* to *DSM-5*  
- Differential Diagnosis  
- Etiology and Treatment  
- Implications for Counselors  
- Somatic Symptom Disorder  
- Illness Anxiety Disorder  
- Conversion Disorder (Functional Neurological Symptom Disorder)  
- Psychological Factors Affecting Other Medical Conditions  
- Factitious Disorder  

**Part Three References**  

**Part Four**  
Future Changes and Practice Implications for Counselors  

**Part Four Introduction**  

**Chapter 16**  
**Looking Ahead: Personality Disorders**  
- Major Changes From *DSM-IV-TR* to *DSM-5*  
- Essential Features  
- Special Considerations  
- Differential Diagnosis  
- Paraphilic Personality Disorder  
- Schizoid Personality Disorder  
- Schizotypal Personality Disorder  
- Antisocial Personality Disorder  
- Borderline Personality Disorder  
- Histrionic Personality Disorder  
- Narcissistic Personality Disorder  
- Avoidant Personality Disorder
## Table of Contents

- Dependent Personality Disorder 305
- Obsessive-Compulsive Personality Disorder 306
- Summary 307
- Alternative Model for Diagnosing Personality Disorders 308
- Using the Alternative DSM-5 Model 313
- Conclusion 315

### Chapter 17

**Practice Implications for Counselors** 317
- Diagnosis and the Counseling Profession 317
- Other Specified and Unspecified Diagnoses 320
- Coding and Recording 320
- Diagnostic Assessment and Other Screening Tools 323
- Cultural Formulation Interview 324
- The Future of the DSM 325

**Part Four References** 327

**Index** 331
The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*, published in 2013 by the American Psychiatric Association, is a dense book that spans 947 pages and describes hundreds of mental disorders. Keeping abreast of the manual’s evolving changes is a tedious but necessary task for counselors. In their text *DSM-5 Learning Companion for Counselors*, Dailey, Gill, Karl, and Barrio Minton provide readers with an exceptionally practical, straightforward, and, most important, readable summary of the *DSM-5*.

One of the many highlights of the text is its focus on clinical utility and counselor practice implications. Care is taken to ensure readers understand what the changes from the *DSM-IV-TR* to *DSM-5* mean to them and how these changes can be applied in their day-to-day practice.

Structural changes to the *DSM-5*, diagnostic changes, and newly added disorders are discussed, and Dailey and colleagues take care to avoid distracting readers with diagnostic material that has not changed. While it is easy to feel overwhelmed by the sheer volume of diagnostic changes presented in the *DSM-5*, the authors ease this transition by highlighting the changes that relate to disorders counselors more commonly treat (e.g., depressive, anxiety, obsessive-compulsive disorders). Attention is also paid to emerging diagnostic trends, such as the proposed personality disorders continuum, which provide readers with information that may be foundational to future *DSM* changes. The authors’ understanding of the manual’s evolutions is obvious, and their discussion of this in Chapter 2 is a must-read for all practicing counselors.

The final chapter is a gem and explains practical *DSM-5* resources that will inform practitioners’ counseling. In terms of assessment, the updated diagnostic coding processes, the diagnostic interview, culturally informed assessments (specifically the Cultural Formulation Interview), and the World Health Organization Disability Assessment Schedule are discussed; these are excellent counselor resources and can serve to enrich counselors’ diagnostic practices. Essential information regarding the upcoming Health Insurance Portability and Accountability Act changes to require *International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10)* diagnoses is also provided and deepens readers’ understanding of the emerging, broader landscape of diagnosis, beyond just the *DSM* system.
Foreword

The material in this Learning Companion is presented in a highly engaging format. The authors address and clearly explain the changes from the DSM-IV-TR to DSM-5. They use lively case studies to illustrate the diagnostic features of the new DSM-5 disorders. They also provide “notes” that highlight the information to which readers should pay special attention. These aforementioned features help readers connect with the essential information they need to successfully use the newest edition of the DSM. The case examples especially are quite thought provoking and serve to bring the newest DSM disorders to life.

In addition, and consistent with counselors’ values and practices, the authors pay close attention to the developmental considerations that have been integrated into the DSM-5 as well as the situational and environmental contexts that relate to the changes. Paralleling the increased emphasis placed on culture in the DSM-5, cultural considerations relating to the diagnoses are also addressed.

The authors are to be commended on providing a resource that is thorough and comprehensive, yet engaging and highly readable—a tall order for a topic as detailed and complex as the DSM system of diagnosis. This book is an essential read for all practicing counselors who wish to stay contemporary in their practices and stay connected with the current edition of the DSM!

—Victoria E. Kress, PhD
Youngstown State University
We wish to acknowledge the following individuals for making this book possible: Vanessa Teixeira, Allison Sanders, Colleen O’Shea, and Vickie Hagan.

We also wish to acknowledge those who touch not only our lives but also our hearts:

**Stephanie F. Dailey**
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**Casey A. Barrio Minton**
To Joel, for his infinite patience, optimism, and affirmation.

♦ ♦ ♦
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♦ ♦ ♦
Regardless of background, training, or theoretical orientation, professional counselors need to 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 (APA; 2013). The DSM-5 and its earlier editions have become the world’s standard reference for client evaluation and diagnosis (Eriksen & Kress, 2006; Hinkle, 1999; Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008). Most important, the manual allows professional counselors to break down the complexity of clients’ presenting problems into practical language for practitioners and clients alike. Sometimes referred to as the “the psychiatric bible” (Caplan, 2012; Kutchins & Kirk, 1997; Perry, 2012), the DSM is intended to be applicable in various settings and used by mental health practitioners and researchers of differing backgrounds and orientations.

Because of the prevalent use of the DSM, professional counselors who provide services in mental health centers, psychiatric hospitals, employee assistance programs, detention centers, private practice, or other community settings must be well versed in client conceptualization and diagnostic assessment using the manual. For those in private practice, agencies, and hospitals, a diagnosis using DSM criteria is necessary for third-party payments and for certain types of record keeping and reporting. Of the 50 states and the U.S. territories, including the District of Columbia, that have passed laws to regulate professional counselors, 34 include diagnosis within the scope of practice for professional counselors (American Counseling Association [ACA], 2012). Even professionals who are not traditionally responsible for diagnosis as a part of their counseling services, such as school or career counselors, should understand the DSM so they can recognize diagnostic problems or complaints and participate in discussions and treatment regarding these issues. Although other diagnostic nomenclature systems, such as the World Health Organization’s (WHO; 2007) International Statistical Classification of Diseases and Related Health Problems (ICD), are available to professional counselors, the DSM is and will continue to be the most widely used manual within the field. For these reasons, the ability to navigate and use the DSM responsibly has become an important part of a professional counselor’s identity.
Counseling Identity and Diagnosis

By definition, counseling is a “professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (ACA, 2013, para. 2). To accomplish this role, practitioners often incorporate diagnosis as one component of the counseling process. Therefore, it is not surprising that ethical guidelines for the profession and accreditation standards for counselor education programs encourage counselors to have an understanding of diagnostic nomenclature. For example, the ACA Code of Ethics (ACA, 2014) Section E.5.a., Proper Diagnosis, requires counselors to “take special care to provide proper diagnosis of mental disorders” (p. 11). The Council for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) requires that counselors learn strategies for collaborating and communicating with other human service providers as part of their common core curricular experiences. Thus, learning outcomes for clinical mental health counselors require demonstrated knowledge regarding the most recent edition of the DSM. Ask any professional counselor and he or she is likely to agree that a thorough understanding of the DSM is an essential aspect of interdisciplinary communication.

Despite widespread guidance encouraging counselors to be familiar with the DSM, utilization of the manual is not without challenges and controversy. Many professional counselors feel unprepared or uncomfortable when faced with the task of assigning clients a diagnosis (Mannarino, Loughran, & Hamilton, 2007). Other professionals are conflicted about the DSM’s focus on psychopathology and feel the mechanistic approach reduces “complex information about people into a few words . . . describing a person’s parts (symptoms) as static” (Mannarino et al., 2007). As counselors are only too aware, clients cannot be encapsulated into fixed categories. Each client comes to counseling with numerous sociocultural issues that the counselor must consider prior to making a diagnosis and putting together an approach for treatment. This is also particularly important given a large body of research that provides support for the far-reaching impact of poverty and social class on psychological and emotional well-being (e.g., American Psychological Association, 2007; Belle & Doucet, 2003; Groh, 2006). For example, studies of children and adolescents from lower socioeconomic families report higher instances of emotional and conduct problems, including chronic delinquency and early onset of antisocial behavior (McLoyd, 1998). Low income has also been correlated to higher levels of family distress and discord as well as higher rates of parental mental illness.

Finally, many counselors believe the “medicalization” of clients ignores the strengths-based, developmental, wellness approach that is the hallmark of the counseling profession (see Chapter 16 of this Learning Companion for information on the wellness vs. the medical model). The introduction of the DSM-5 adds to this controversy, presenting counselors with a new challenge—the application of a new nomenclature system.

Why We Wrote This Learning Companion

We wrote this Learning Companion to make the DSM-5 accessible to professional counselors by breaking down the complexity of the changes and additions found within the revised manual. Because the CACREP 2009 Standards require that programs “provide an understanding of the nature and needs of persons at all developmental levels and in multicultural contexts, . . . including an understanding of psychopathology and situational and environmental factors that affect both normal and abnormal behavior” (p. 9), we believe it essential that new and seasoned professional counselors, counselor educators, and counseling students have easily accessible and accurate information regarding the DSM-5 and implications of changes for current counseling practice.
To understand changes from the *DSM-IV-TR* (APA, 2000) to the *DSM-5* (APA, 2013), we believe it is important for the reader to first understand the revision process. In the following section, we describe the revision process of the *DSM-5* and the role counselors took in its inception. Readers will find a comprehensive description of structural and philosophical changes to the manual, including a history of the manual's iterations, in Chapter 2.

**The Revision Process**

The *DSM-5*, after 14 years of debate and deliberation, was intended to be the most radical revision to date (Frances & First, 2011; Jones, 2012b; Miller & Levy, 2011). Beginning in 1999, a year before the *DSM-IV-TR* was published, APA began collaboration with the National Institute of Mental Health (NIMH) on a new edition. The intent of these meetings was to develop a more scientifically based manual that would increase clinical utility while maintaining continuity with previous editions (APA, 2012a). The process began with an initial *DSM-5* Research Planning Committee Conference, held in 1999, in which APA and NIMH deliberated on a research agenda and priorities for the new manual. Additional conferences, sponsored by APA, NIMH, and WHO, took place in 2000 and resulted in the formation of six work groups. These initial work groups focused on nomenclature, neuroscience and genetics, developmental issues and diagnosis, personality and relational disorders, mental disorders and disability, and cross-cultural issues. In 2002, a series of six white papers was published with the intent of “providing direction and potential incentives for research that could improve the scientific basis of future classifications” (Kupfer, First, & Regier, 2002, p. xv). Two final manuscripts were published in 2007. One focused on mental disorders in infants, young children, and older persons and the other on gender, cultural, and spiritual issues.

After the release of the initial research agenda for the *DSM-5*, it became clear that further deliberation was needed with regard to nomenclature, neuroscience, developmental science, personality disorders, and the relationship between culture and psychiatric diagnoses (APA, 2000; Kupfer et al., 2002). Steered by APA, NIMH, and WHO, 13 conferences were held between 2004 and 2008 in which participants discussed relevant diagnostic questions and solicited feedback from colleagues and other professionals regarding potential changes. Findings from these conferences facilitated the research base for proposed revisions for the *DSM-5* and fueled the agenda of the *DSM-5* work groups (see Kupfer et al., 2002, for the full *DSM-5* research agenda).

In 2007, APA officially commissioned the *DSM-5* Task Force, made up of 29 members, including David J. Kupfer, MD, chair, and Darrel A. Regier, MD, MPH, vice-chair (APA, 2012a). The *DSM-5* Task Force expanded the work groups from six to 13. These included attention-deficit/hyperactivity disorder (ADHD) and disruptive behavior disorders; anxiety, obsessive-compulsive spectrum, posttraumatic, and dissociative disorders; childhood and adolescent disorders; eating disorders; mood disorders; neurocognitive disorders; neurodevelopmental disorders; personality disorders; psychotic disorders; sexual and gender identity disorders; sleep-wake disorders; somatic symptoms disorders; and substance-related disorders. Although each of these work groups investigated specific disorders, cross-collaboration was common. Kupfer and Regier provided clear direction to the work groups to, among other things, eradicate the use of not otherwise specified (NOS) diagnoses within categories, do away with functional impairments as necessary components of diagnostic criteria, and use empirically based evidence to justify diagnostic classes and specifiers (Gever, 2012; Regier, Narrow, Kuhl, & Kupfer, 2009). With these marching orders, each work group proposed draft criteria and changes for the new manual.

Three rounds of public comment regarding proposed changes took place between April 2010 and June 2012. An estimated 13,000 mental health professionals commented on the
Introduction and Overview

proposed criteria (APA, 2012c, 2012d). Additionally, mental health professionals conducted field trials to “assess the feasibility, clinical utility, reliability, and (where possible) the validity of the draft criteria and the diagnostic-specific and cross-cutting dimensional measures being suggested for DSM-5” (APA, 2010, p. 1). Two field trial study designs were administered (APA, 2010, 2011b). The first trial, held between April 2010 and December 2011, took place in 11 large academic or medical centers and involved a total of 279 clinicians (APA, 2012b, 2012c). The second trial, which included solo or small group practices, took place between October 2010 and February 2012. APA recruited a volunteer sample of psychiatrists, psychologists, licensed clinical social workers, licensed counselors, licensed marriage and family therapists, and licensed psychiatric mental health nurses to participate in the second field trial (APA, 2012b, 2012c). Feedback from public comment periods and field trials was shared with work group members, who edited proposed criteria as indicated. The final version of the DSM-5 went before the APA Board of Trustees in December 2012 and was released in May 2013. The following outlines the complete timeline of the development of the DSM-5.

Timeline of DSM-5

1999–2001 Development of the DSM-5 research agenda
2006 Appointment of DSM-5 Task Force
2007 Appointment of DSM-5 work groups
2007–2011 Literature review and data reanalysis
2010–2011 First phase field trials
2010–2012 Second phase field trials
July 2012 Final draft of DSM-5 for APA review
May 2013 DSM-5 released to the public

Revision Feedback

Although no professional counselor was invited to serve on the DSM-5 Task Force, ACA served as an important advocate for professional counselors during the revision process. Through advocacy efforts of the ACA Professional Affairs Office and the ACA DSM-5 Revisions Task Force, two ACA presidents sent letters to APA indicating concern over proposed changes. The first was sent by Dr. Lynn E. Linde, ACA 2009–2010 president, to Dr. David J. Kupfer, DSM-5 Task Force chair. The letter indicated that ACA members had concerns regarding five areas of particular importance to professional counselors: (a) applicability across all mental health professions, (b) gender and culture, (c) organization of the DSM-5 multiaxial system, (d) lowering of diagnostic thresholds and combining diagnoses, and (e) use of dimensional assessments. The second letter was sent by Dr. Don W. Locke, ACA 2011–2012 president, informing Dr. John Oldham, APA president, that licensed professional counselors were the second largest group to routinely use the DSM-IV-TR. He noted uncertainty among professional counselors about the quality and credibility of the DSM-5 and included a prioritized list of concerns APA should consider before publishing the DSM-5. APA responded to this letter on November 21, 2011 (APA, 2011a).

In addition to feedback provided by ACA, several divisions of the American Psychological Association voiced concern about the writing process of the DSM-5 (Jones, 2012a). As a result, the Society for Humanistic Psychology, Division 32 of the American Psychological Association, sponsored a petition outlining its concerns and inviting other mental health professionals, including counselors, to sign this petition (for a review of these concerns, see British Psychological Society, 2011). It is important to note that nine out of 19 ACA divisions endorsed this petition, including the Association for Adult Development and Aging; Association for Creativity in Counseling; American College Counseling Associa-
Professional counselors are responsible for understanding changes and using the *DSM-5* in a manner consistent with the mission of our profession and the *ACA Code of Ethics* (ACA, 2014). A thorough understanding of the revision process, changes, rationale for changes, and impact of changes will help professional counselors decide how they would like to continue to use the *DSM-5* in practice, consider possibilities for future revisions, and ensure advocacy so counselors have a greater voice in the next revision of the *DSM*.

**Organization of the DSM-5 Learning Companion for Counselors**

In Chapter 2 of this *Learning Companion*, we outline major structural and philosophical changes adopted for the *DSM-5*, such as the elimination of the multiaxial system. We also outline major diagnostic changes, such as the removal of the bereavement clause from major depressive disorder. In addition, we discuss major changes that influence numerous chapters within the *DSM-5*, for example, the removal of NOS and the inclusion of other specified and unspecified disorders to replace all NOS diagnoses.

Following Chapter 2, this *Learning Companion* includes four separate parts, grouped by diagnostic similarity and relevance to the counseling profession. In each of the four parts, we provide a basic description of the diagnostic classification and an overview of the specific disorders covered, highlighting essential features as they relate to the counseling profession. We also provide a comprehensive review of specific changes, when applicable, from the *DSM-IV-TR* to the *DSM-5*. When specific or significant changes to a diagnostic category or diagnosis have not been made, we provide a general review of either the category or the diagnosis, but we refrain from providing the reader with too much detail because the purpose of this *Learning Companion* is to focus on changes from the *DSM-IV-TR* to the *DSM-5*. For example, we do not go into great detail about personality disorders, found in Part Four, because the diagnostic criteria for these disorders have not changed. What we do focus on, however, is the proposed model for diagnosing personality disorders that may significantly affect how counselors diagnose personality disorders in future versions of the *DSM*.

Readers will find, within each part of the book, individual chapters that highlight key concepts of each disorder (including differential diagnoses), new or revised diagnostic criteria, and implications for professional counseling practice. We provide “Notes” to highlight significant information and include case studies to assist counselors in further understanding and applying the new or revised diagnostic categories. All case studies are fictitious composites and do not depict real clients. Any similarity to any person or case is simply coincidental.

Readers should also note that we provide more detail for disorders that counselors are more likely to see in their clients. Therefore, because this *Learning Companion* is organized in order of diagnoses counselors are most likely to diagnose, each consecutive part of the book provides the reader with less specific detail about each diagnostic grouping. For example, Part One includes a detailed synthesis for key disorders, including cultural considerations, differential diagnosis, and special considerations for counselors. We have also included a description of other specified and unspecified diagnoses for each diagnostic class. Conversely, Part Three provides less detail about neurodevelopmental disorders because these diagnoses are typically made by other professionals.

Part One, Changes and Implications Involving Mood, Anxiety, and Stressor-Related Concerns, includes chapters regarding depressive disorders, bipolar and related disorders,
Introduction and Overview

anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, and gender dysphoria. We listed this section first because these disorders, both within and outside of the counseling profession, are some of the highest reported mental disturbances within the United States (Centers for Disease Control and Prevention [CDC], 2011). Readers will note that this is the only section in which other specified and unspecified diagnoses are listed.

Part Two, Changes and Implications Involving Addictive, Impulse-Control, and Specific Behavior-Related Concerns, includes chapters focused on behavioral diagnoses such as substance use and addiction disorders; impulse-control and conduct disorders; and specific behavioral disruptions consisting of feeding and eating, elimination, sleep-wake, sexual dysfunction, and paraphilic disorders. Similar to the disorders found in Part One, counselors are often exposed to the disorders listed in Part Two within clinical practice, but these disorders frequently manifest through more visible, external behavioral concerns rather than less visible, internal experiences (i.e., depression vs. sexual dysfunction). Moreover, counselors may or may not diagnose these disorders. This is not to say that counselors do not frequently diagnose substance use disorders. However, compared with depression and anxiety disorders, substance use disorders are more often diagnosed by a combination of counselors and other health professionals.

Part Three, Changes and Implications Involving Diagnoses Commonly Made by Other Professionals, includes chapters focused on neurodevelopmental, schizophrenia spectrum, and other psychotic, dissociative, neurocognitive, and somatic disorders. Many of these disorders, specifically neurodevelopmental and somatic issues, require highly specialized assessment or extensive medical examination by physicians or other qualified medical professionals. These chapters focus on helping professional counselors understand major changes and the potential impact of these changes on the clients counselors serve. We do not provide a detailed description of each disorder in this chapter; rather, we address major changes, if applicable, and considerations for counselors.

Part Four, Future Changes and Practice Implications for Counselors, addresses future changes to the DSM as well as clinical issues related to professional counseling. Whereas all parts of the book focus on professional counselors, this part highlights clinical utility of the DSM-5 as well as future changes that may affect the counseling profession. For example, Chapter 16 addresses the personality disorders section of the DSM-5. Although personality disorders did not change from the DSM-IV-TR to the DSM-5, proposed changes were included in Section III of the DSM-5. If these changes were implemented, they would significantly alter the way counselors diagnose and treat clients with these disorders.

Chapter 17 addresses issues such as the diagnostic interview, the nonaxial system, cultural inclusion, and assessment instruments such as the WHO Disability Assessment Schedule (Version 2.0; WHO, 2010). This chapter also contains information regarding diagnostic coding and changes counselors can expect with the October 2014 revision to the ICD-10-Clinical Modification (ICD-10-CM; CDC, 2014) coding required for Health Insurance Portability and Accountability Act of 1996 (HIPAA) purposes. We also explore ways in which counselors can continue to be an active part of future revisions of diagnostic nomenclature systems.

References


In this chapter, we highlight major structural modifications of the *DSM-5* (APA, 2013), including removal of the multiaxial system and changes to chapter order; philosophical changes, such as the proposed use of dimensional and new cross-cutting assessments; and major diagnostic changes from the *DSM-IV-TR* to the *DSM-5*. To help readers better understand the revision process and the philosophy behind it, we begin with a brief description of the historical background and evolution of the *DSM*.

### History of the *DSM*

The original *DSM*, published by the APA in 1952, was psychiatry’s first attempt to standardize the classification of mental disorders. Developed by the APA Committee on Nomenclature and Statistics, the *DSM-I* (APA, 1952) served as an alternative to the sixth edition of the *ICD* (WHO, 1949), which, for the first time, included a section for mental disorders (APA, 2000). Differing slightly from the *ICD*, which primarily served as an international system to collect health statistics, the *DSM-I* focused on clinical utility and was grounded in psychodynamic formulations of mental disorders (Sanders, 2011). This version highlighted prominent psychiatrist Adolf Meyer’s (1866–1950) psychobiological view, which posited that mental disorders denoted “reactions” of the personality to biological, psychological, or social aspects of client functioning (APA, 2000). The *DSM-I* included three categories of psychopathology (organic brain syndromes, functional disorders, and mental deficiency) and 106 narrative descriptions of disorders in about as many pages. Only one diagnosis, adjustment reaction of childhood/adolescence, was applicable to children (Sanders, 2011).

Meyer’s influence was abandoned in the initial revision of the *DSM-II* published in 1968. This version contained 11 categories and 182 disorders (APA, 1968). Similar to the previous version, the development of the *DSM-II* coincided with the development of the WHO’s (1968) revised *ICD-8*. Although only incremental changes were evident, the focus of the manual shifted from causality to psychoanalysis, as evidenced by the removal of the word *reactions* and retention of terms such as *neuroses* and *psychophysiologic disorders* (Sanders, 2011). With the intent on reform, this shift was significant because separation...
meant removing unverified or speculative diagnoses from the manual. Critics, however, argued that actual separation of diagnostic labels from etiological origins would not actually occur until the next revision (Rogler, 1997).

Work on the third version, *DSM-III*, began in 1974 and continued until the edition was published in 1980. A considerable divergence from previous editions, the *DSM-III* represented a dramatic shift with inclusion of descriptive diagnoses and emphasis on the medical model (APA, 1980; Wilson, 1993). This profound reframing introduced a biopsychosocial model to diagnostic assessment with an emphasis on empirical evidence that represented a clear follow-through on previous attempts to separate the *DSM* from psychoanalytic origins. Supporters claimed “theoretical neutrality” of the *DSM-III* (Maser, Kaelber, & Weise, 1991, p. 271). As Rogler (1997) argued, “The *DSM-III* was an official attempt to abruptly, not gradually, reduce reliance on the vagaries of the diagnosticians’ subjective understandings by specifying sets of diagnostic criteria” (p. 9).

With the publication of the *DSM-III*, mental health professionals repositioned themselves toward positivistic, operationally defined symptomatology based on specific descriptive measures (Wilson, 1993). This modification included the introduction of explicit diagnostic criteria (i.e., a checklist) as opposed to narrative descriptions. The *DSM-III* also introduced the multiaxial system and diagnostic classifications free from specific theoretical confines or etiological assumptions. This version integrated demographic information such as gender, familial patterns, and cultural features into diagnostic classifications (Sanders, 2011). On the basis of these philosophical changes, professional counselors began to emphasize the structured interview and insisted on empirically validating *DSM-III* diagnostic criteria. The age of empirically based treatments had arrived, and widespread use of the *DSM-III*, as opposed to the *ICD-9* (WHO, 1975), became commonplace. Wilson (1993) wrote,

The biopsychosocial model [alone] did not clearly demarcate the mentally well from the mentally ill, and this failure led to a crisis in the legitimacy of psychiatry by the 1970s. The publication of *DSM-III* in 1980 represented an answer to this crisis, as the essential focus of psychiatric knowledge shifted from the clinically-based biopsychosocial model to a research-based medical model. (p. 399)

Intended only to be a minor change to the third version, the revised *DSM-III-R* (APA, 1987) renamed, added, and deleted categories; made changes to diagnostic criteria; and increased reliability by incorporating data from field trials and diagnostic interviews (APA, 2000; Blashfield, 1998; Scotti & Morris, 2000). Despite these innovations, the *DSM-III* and *DSM-III-R* were profoundly criticized. The manual had increased from 106 to 297 diagnoses (APA, 1987). Descriptions of Axis I disorders topped at 300 pages whereas explanations of Axis IV and V disorders totaled only two pages, leading many to question the multiaxial system (Rogler, 1997). Additionally, critics questioned field trials and claimed lack of objectivity among researchers, further contributing to strong criticism of the *DSM-III* and *DSM-III-R*.

Heavy critique of the *DSM-III* and its revision led to relatively mild changes to the *DSM-IV*, published in 1994. Despite few changes, the revision process was considerable and involved a steering committee, 13 work groups, work group advisors, extensive literature reviews, and numerous field trials to ensure clinical utility. The *DSM-IV* (APA, 1994) included 365 diagnoses; and at 886 pages, it was almost 7 times the length of the *DSM-I*. A “text revision” (*DSM-IV-TR*) was published in 2000 and included additional empirically based information for each diagnosis as well as changes to diagnostic codes for the purpose of maintaining consistency with the *ICD* (APA, 2000). In the *DSM-IV-TR* (APA, 2000), wording of the manual was modified in an attempt to differentiate people from their diagnoses. For example, phrases such as “a schizophrenic” were modified to read “an individual with schizophrenia” (Scotti & Morris, 2000).
Like their predecessors, the DSM-IV and DSM-IV-TR were heavily critiqued by helping professionals (Eriksen & Kress, 2006). Many felt the manual leaned too heavily on the medical model with its rigid classification system, despite claims of diagnostic neutrality (Eriksen & Kress, 2006; Ivey & Ivey, 1998; Scotti & Morris, 2000). Issues of comorbidity, questionable reliability, and controversial diagnoses were hot topics among critics; the multiaxial system continued to be controversial (Houts, 2002; Malik & Beutler, 2002). Because of the changing nature of how the DSM was being used and by whom, many practitioners began demanding that a more holistic or dimensional approach be used and that psychometrically sound assessments be included (Kraemer, 2007). Other critics, specifically those directly involved in writing the DSM-5, advocated for incorporating scientific advances from psychiatric research, genetics, neuroimaging, cognitive science, and pathophysiology (functional changes associated with or resulting from disease or injury) into diagnostic nosology (Kupfer & Regier, 2011).

Some counselors, in particular, believed that overreliance on DSM diagnoses can “narrow a counselor’s focus by encouraging the counselor to only look for behaviors that fit within a medical-model understanding of the person’s situation” (Eriksen & Kress, 2006, p. 204). In contrast to those who support the medical model, many counselors use diagnosis as only one aspect of understanding the client. Most counselors view individuals as having strengths and difficulties across myriad emotional, cognitive, physiological, social, occupational, cultural, and spiritual areas. Counselors recognize the whole person and nurture a strength-based approach to achieve wellness, not simply reduce symptomatology. Myers, Sweeney, and Witmer (2000) defined wellness as

A way of life oriented toward optimal health and well-being, in which body, mind, and spirit are integrated by the individual to live life more fully within the human and natural community. Ideally, it is the optimum state of health and well-being that each individual is capable of achieving. (p. 252)

The controversial issues of rigid classification, comorbidity, questionable reliability, and controversial diagnoses were the driving force of numerous structural and philosophical changes included in the DSM-5. Information regarding these major changes is provided in the next section.

**DSM-5 Structural Changes**

The DSM-5 includes approximately the same number of disorders as the DSM-IV-TR. This goes against a popular trend within health care to increase, rather than decrease, the number of diagnoses available to practitioners (APA, 2013). Despite being similar in number, several major changes affect the manual as a whole. Unlike the previous version that was organized by 16 diagnostic classes, one general section, and 11 appendixes, the DSM-5 is divided into three sections, 20 diagnostic classes, two general sections for medication-induced problems and other conditions that may be a focus of clinical attention, and seven appendixes. It also lists two sets of ICD codes, using ICD-9-CM (CDC, 1998) codes as the standard coding system with ICD-10-CM (CDC, 2014) codes in parentheses. ICD-10-CM codes are included because as of October 1, 2014, all practitioners must be in alignment with HIPAA, which requires use of ICD-10-CM codes. For more information, Part Four of this Learning Companion comprehensively reviews how diagnostic coding systems will change and implications of these modifications for counselors.

**Section Overview**

Section I of the DSM-5 provides a summary of revisions and changes as well as information regarding utilization of the revised manual. Section II includes all diagnoses broken into
20 separate chapters ordered by similarity to one another. Because comorbid symptoms are clustered together, counselors can now better differentiate between disorders that are distinctively different but have similar symptom characteristics or etiology (e.g., body dysmorphic disorder vs. obsessive-compulsive disorder; acute stress disorder vs. adjustment disorder). Section III includes conditions that require further research before they can be considered for adoption in an upcoming version of the DSM, dimensional assessment measures, an expanded look at how practitioners can better understand clients from a multicultural perspective, and a proposed model for diagnosing personality disorders.

**Cultural Inclusion**

Section III (see pp. 749–759 of the DSM-5) includes special attention to diverse ways in which individuals in different cultural groups can experience and describe distress. The manual provides a Cultural Formulation Interview (pp. 750–757 of the DSM-5) to help clinicians gather relevant cultural information. Expanding on information provided in the DSM-IV-TR, the Cultural Formulation Interview calls for clinicians to outline and systematically assess cultural identity, cultural conceptualization of distress, psychosocial stressors related to cultural features of vulnerability and resilience, cultural differences between the counselor and client, and cultural factors relevant to help seeking. The DSM-5 also includes descriptions regarding how different cultural groups encounter, identify with, and convey feelings of distress by breaking up what was formerly known as culture-bound syndromes into three different concepts. The first concept is cultural syndromes, a cluster of co-occurring symptomatology within a specific cultural group. The second is cultural idioms of distress, linguistic terms or phrases used to convey suffering within a specific cultural group. The third concept is cultural explanation or perceived cause, mental disorders unique to certain cultures that serve as the reason for symptoms, illness, or distress. This breakdown improves clinical utility by helping clinicians more accurately communicate with clients, so that they are able to differentiate disorders from nondisorders when working with clients from varied backgrounds.

**Personality Disorders**

Section III of the DSM-5 also provides an alternative model for diagnosing personality disorders. This model is a radical change from the current diagnostic structure, introducing a hybrid dimensional-categorical model, which evaluates symptomatology and characterizes five broad areas of personality pathology. As opposed to separate diagnostic criteria, this proposed model identifies six personality types with a specific pattern of impairments and traits. We review this model and the Cultural Formulation section in Part Four of this Learning Companion.

**Adoption of a Nonaxial System**

One of the most far-reaching structural modifications to the DSM-5 is the removal of the multiaxial system and discontinuation of the Global Assessment of Functioning (GAF) scale. Table 2.1 includes a comparison of the traditional multiaxial and the new nonaxial system. Axes I, II, and III are now combined with the assumption that there is no differentiation between medical and mental health conditions. Rather than list psychosocial and contextual factors affecting clients on Axis IV, counselors will now list V codes or 900 codes (used for conditions related to neglect, sexual abuse, physical abuse, and psychological abuse) as stand-alone diagnoses or alongside another diagnosis as long as the stressors are relevant to the client’s mental disorder(s). An expanded listing of V codes is included in the DSM-5. Although the DSM-5 does not include direction for formatting, counselors may also use special notations for psychosocial and environmental considerations relevant to the diagnosis. Similarly, counselors will no longer note a GAF score on Axis V. Rather, the DSM-5 advises that clinicians find ways to note distress and/or disability in functioning, perhaps using the World Health Organization Disability Assessment Schedule 2.0 (WHO-