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DSM-5-TR
Learning Companion for Counselors

DSM-5-TR

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American Counseling Association
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DSM-5-TR
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Dedication

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

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Foreword

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*), published in 2022 by the American Psychiatric Association, is a dense book that spans 1,048 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-TR Learning Companion for Counselors*, the authors Gill, Dailey, Karl, and Barrio Minton provide readers with an exceptionally practical, straightforward, and, most importantly, readable summary of the *DSM-5-TR*.

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*, and the *DSM-5* to *DSM-5-TR*, mean to them and how these changes can be applied in their day-to-day practice.

Structural changes to the *DSM-5-TR*, diagnostic changes, and newly added disorders are discussed, and Gill and colleagues take care to avoid distracting readers with diagnostic material that has not changed. It is easy to feel overwhelmed by the sheer volume of diagnostic changes presented in the updated iteration of the *DSM*, yet the authors ease this transition by highlighting the changes that relate to disorders counselors more commonly address (e.g., depressive, anxiety, obsessive-compulsive disorders). Consistent with the new text revision, attention is also paid to the risk factors associated with systematic racism and discrimination and to the intentional removal of stigmatizing language from the manual. 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 fifth chapter is a gem and explains practical *DSM-5* resources that will inform practitioners' counseling practice. In terms of assessment, the authors discuss updated diagnostic coding processes, the diagnostic interview, culturally informed assessments (specifically the Cultural Formulation Interview), and the World Health Organization Disability Assessment Schedule; these are excellent counselor resources and can serve to enrich diagnostic practices. Essential information regarding the upcoming changes to the

Health Insurance Portability and Accountability Act 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.

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*/*DSM-5-TR*. They apply lively case studies to illustrate the diagnostic features of the newest *DSM-5-TR* disorders. The authors also provide "notes" that highlight the information to which readers should pay special attention. These features help readers connect with the essential information they need to successfully use the newest edition of the *DSM*. The case examples are thought provoking and serve to bring the *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-TR*, as well as the situational and environmental contexts that relate to the changes. Paralleling the increased emphasis placed on culture in the *DSM-5-TR* and within our broader society, cultural considerations relating to the diagnoses are also addressed.

The authors are to be commended for 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

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◆

About the Authors

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Chapter 1

Introduction and Overview

Regardless of background, training, or theoretical orientation, professional counselors need to have a thorough understanding of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*DSM-5-TR*), published by the American Psychiatric Association (APA, 2022a). The *DSM-5* (APA, 2013) and its earlier editions have become the world's standard reference for client evaluation and diagnosis (Eriksen & Kress, 2006; Hinkle, 1999; Zalaquett et al., 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 (Dailey et al., 2014b). Sometimes controversially referred to as the "the psychiatric bible" (see Caplan, 2012; Kutchins & Kirk, 1997), the *DSM* is intended to be applicable in various settings and used by mental health practitioners and researchers of differing backgrounds and orientations (Dailey et al., 2014b).

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 (Dailey et al., 2014b; Kress et al., 2013). Of the 50 states and U.S. territories, including the District of Columbia, that have passed laws to regulate professional counselors, 36 include diagnosis within the scope of practice for professional counselors and 19 do not directly restrict or address diagnosis (Norton, 2022). 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 (Norton, 2022). Although other diagnostic nomenclature systems such as the World Health Organization's (WHO, 2022) *International Statistical Classification of Diseases and Related Health Problems, 11th Revision* (*ICD-11*) 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

Counseling is defined as a "professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (American Counseling Association [ACA], 2013, para. 2). To accomplish this role, practitioners often incorporate diagnosis as one component of the counseling process (Norton, 2022). Therefore, it is not surprising that ethical guidelines for the profession and accreditation standards for counselor education programs encourage counselors to understand 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, 2024) 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 specialty areas, including addictions counseling; clinical mental health counseling; clinical rehabilitation counseling; and marriage, couple, and family counseling, require demonstrated knowledge regarding the most recent edition of the *DSM*. Any professional counselor 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 (Bonino & Hanna, 2018). Many professional counselors feel unprepared or uncomfortable when faced with the task of assigning clients a diagnosis (Mannarino et al., 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 before making a diagnosis and putting together an approach for treatment. This is 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, 2017; Hodgkinson et al., 2017; Marbin et al., 2022). 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 (Shaw & Shelleby, 2014). 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 (Frances, 2013). Others posit methods for integrating this system into a multicultural, wellness-based approach to clients (Tomlinson-Clarke & Georges, 2014). The change from the *DSM-5* to the *DSM-5-TR* renews this controversy, presenting counselors with a new challenge—the application of an updated nomenclature system.

Why We Updated This *Learning Companion*

The *DSM-5* (APA, 2013) represented the most radical revision of the *DSM*, as well as the most controversial (Dailey et al., 2014b). We originally designed the *DSM-5 Learning Companion for Counselors* (Dailey et al., 2014a) to assist counselors with transitioning from the *DSM-IV-TR* (APA, 2000) to the *DSM-5* (APA, 2013). The original *Learning Companion* was widely distributed and was a bestseller for years. During that time frame, research and clinical use of the *DSM-5* increased significantly, with over 98% of counselors stating they intend to use the nosology (Gayle & Raskin, 2017). Given this, we are compelled to provide counselors with an updated version of the *Learning Companion* based on the changes

presented in the *DSM-5-TR*, alongside updated research regarding etiology of disorders, impact of systemic injustice on mental health, and evidence-based practice.

The purpose of this book remains relatively consistent with our original text, but there are noteworthy changes corresponding with the new *DSM*. In an effort to emphasize the distinct foci of counseling as prevention, development, and wellness-based modality that operates within the umbrella of social justice, we begin by addressing sociocultural issues in diagnosis and the *DSM-5-TR*, culturally responsive case conceptualization, and practice implications for counselors. We highlight culturally responsive practice, which includes using language designed to avoid perpetuating systematic racism and oppression, promoting gender-inclusive terminology, and expanding counselor understanding regarding how social determinants of health play a role in health outcomes. For example, we incorporate the impact of adverse childhood and community experiences to include systemic racism and oppression, which can affect health and mental health. Because diagnosis is fundamental to case conceptualization and evidence-based treatment, we focus on the integration of case conceptualization and culture and cover sociocultural issues and social determinants of mental health, diagnostic bias, and strategies for buffering diagnostic bias. Toward that purpose, we provide two new chapters, including Sociocultural Issues in Diagnosis in the *DSM-5-TR* (Chapter 3) and Culturally Responsive Case Conceptualization and Treatment Planning: Cultural Formulation (Chapter 4).

The *DSM-5-TR* includes diagnostic changes and additions that will impact the work of counselors. For example, the revised manual contains changes to depressive disorder, including the addition of prolonged grief disorder, changes to the wording of Criterion D for major depressive disorder, changes to the wording for persistent depressive disorder, the restoration of unspecified mood disorder, the addition of major depressive episode superimposed to other specified depressive disorder, and updated language for depressive disorder due to another medical condition. Likewise, there are several changes in the bipolar and related disorders chapters (APA, 2022a). Throughout this book, we address major changes to the nosology, as well as additional changes, such as the addition of a section on "association with suicidal thoughts or behavior" to applicable diagnoses and the acknowledgment of new *ICD-10–Clinical Modification* (*ICD-10-CM*; National Center for Health Statistics, 2023) codes for suicidal behavior and nonsuicidal self-injury. Minor changes, including updates to descriptive text and updated codes for all disorders, are highlighted in each chapter where applicable. In alignment with advances in clinical knowledge and research, we update all chapters with recent data on prevalence, risk, prognosis, differential diagnosis, and comorbidity. For each diagnosis, we highlight culture-related diagnostic considerations, functional barriers for clients, and other relevant features of particular concern for professional counselors. Furthermore, we incorporate updated research regarding etiology, intersections with sociocultural context, and evidence-based practice. Holistically, this edition reflects the *DSM-5-TR*'s focus on ethnoracial equity and inclusion, highlighting intersections between culture, racism, discrimination, oppression, and misdiagnosis.

The Revision Process

APA began revising the *DSM-5* in Spring 2019, a process that included 200 mental health professionals. Most of these professionals worked on the original *DSM-5* and were either psychiatrists or psychologists (APA, 2022d). Counselors were not well represented in this process, with just 6% of other professionals who fell into the "other health professionals" category (Norton, 2022). A DSM-5 Task Force, a DSM Steering Committee, and a Revision Subcommittee became the original working groups. However, APA created 20 expert disorder review groups and four cross-cutting review groups, whose purpose was to focus on the areas in which they were experts (APA, 2022a, 2022d). Any recommended

revisions that were included in the *DSM-5-TR* were reviewed and accepted by the Steering Committee and the APA Board of Trustees.

In September 2022, APA published the *DSM-5-TR* Update: Supplement to the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (APA, 2022c). This document introduced changes to the *DSM-5-TR*. Many of these changes were noteworthy, such as the removal of suicidal behavior disorder from the Conditions for Further Study chapter. Although suicidal behavior disorder was removed from that section, the diagnostic codes in "other conditions that may be a focus of clinical attention" related to suicidal behavior were not removed and are still available for clinical use (APA, 2022c). Within the diagnostic criteria of certain disorders, the *DSM-5-TR* authors changed language regarding suicide, intending to be more accurate while reducing stigma surrounding the act. For example, both bipolar I and II disorders, as well as major depressive disorder, should state "a specific suicide plan, or a suicide attempt," replacing "or a suicide attempt or specific plan for committing suicide." A differential of prolonged grief disorder was added to major depressive disorder, and the codes for prolonged grief disorder, other specified trauma- and stressor-related disorder, and hepatic encephalopathy, listed under catatonic disorder due to another medical condition, were updated in keeping with the *ICD*-10-CM. Codes for opioid-induced anxiety disorder, mild, moderate, and severe were also updated, and additions as well as coding updates were made throughout for neurocognitive disorders. Additional coding updates were made to the "conditions for further study," and a new condition, "impairing emotional outbursts," was added. Language changes were made within the assessment measures and to the criteria of depressive episodes with short-duration hypomania in Section III of the manual (APA, 2022c).

We purchased physical copies of the *DSM-5-TR* published before these changes and again in January 2023. We found that the changes in the *DSM-5-TR* supplement (APA, 2022c) were applied inconsistently. For example, suicidal behavior disorder is not included in the December manual, but prolonged grief disorder is not included in the differential diagnosis for major depressive disorder, nor is the language regarding suicide updated for major depressive disorder, depressive episodes with short-duration hypomania, and bipolar disorders. We recommend that counselors become familiar with the September 2022 supplement (see APA, 2022c), and we describe the changes related to this supplement in this *Learning Companion*. Counselors are encouraged to use the information provided here when diagnosing. Although removed from the *DSM-5-TR* with the supplement, the description of suicidal behavior disorder is included here because the codes are available for clinical use, and we believe that understanding the basis for these codes is important for counselors. In October 2022, APA published the *DSM-5-TR* Neurocognitive Disorders Supplement: Updated Excerpts for Delirium Codes Major and Mild Neurocognitive Disorders, further updating these codes; this document was updated again in November 2022 (APA, 2022b).

Another supplement was released in September 2023. This document addressed coding changes for Parkinson's disease and inadequate housing (in the Other Conditions That May Be a Focus of Clinical Attention chapter), as well as a listing of *ICD*-10 coding updates. Further text updates included for differential diagnosis for three disorders. For delusional disorder and schizophrenia, the differential diagnosis regarding obsessive-compulsive and related disorders was elucidated. The language regarding differential diagnosis for conduct disorder was clarified, aligning this with Criterion E of adjustment disorders. The authors also included warning regarding the use of clinical judgment and not to use the manual in a "rigid cookbook fashion" (APA, 2023, p. 3). More information is located on the American Psychiatric Association website.

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

In Chapter 2 of this *Learning Companion*, we describe the history of the *DSM* and some major modifications in the *DSM-5*. We provide an overview of the creation of the manual and an in-depth look at the revisions process for this new text revision. We offer an overview of the changes made in the *DSM-5-TR*, along with implications for clients and counselors, and the speculation regarding the future of the nosology.

Chapter 2 also addresses issues such as the nonaxial system, neurobiological foundations, other and unspecified diagnoses, and assessment instruments such as the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0; WHO, 2010). In addition, Chapter 2 contains information regarding diagnostic coding and changes counselors can expect consistent with the *ICD-10-CM* (National Center for Health Statistics, 2023) 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.

Following Chapter 2, this *Learning Companion* includes four separate parts, with each of the chapters grouped first by clinical utility and practice implication for counseling. The next three portions are grouped by diagnostic similarity and relevance to the counseling profession. In each of the final three 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-5* to the *DSM-5-TR*. When there are no specific or significant changes made to a diagnostic category or diagnosis, 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-5* to the *DSM-5-TR*. For example, we do not go into detail about personality disorders, found in Part Three, because the diagnostic criteria for these disorders have not changed.

Within each part of the book, readers will find individual chapters highlighting 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, this *Learning Companion* is organized in order of diagnoses counselors are most likely to diagnose, and each consecutive part of the book provides the reader with less specific detail about each diagnostic grouping. For example, Part Two 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 Four provides less detail about neurodevelopmental disorders because these diagnoses are typically made by other professionals.

Part One, Clinical Utility and Practice Implications for Counselors, starts with Chapter 3 covering sociocultural issues in diagnosis in the *DSM-5-TR*, including ethics, health disparities, ecological models and differences in expressing distress, as well as the impact of adverse childhood experiences. Here, we discuss the crucial nature of counselor self-awareness, addressing personal bias and systemic influences on diagnosis. In Chapter 4, culturally responsive case conceptualization is covered, and a model for integrating the impact of culture into effective case conceptualization is provided. Although all parts of the

book focus on professional counselors, these chapters highlight the clinical utility of the *DSM-5* as well as future changes that may affect the counseling profession. For example, Chapter 14 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.

Part Two, Changes and Implications Involving Mood, Anxiety, and Stressor-Related Concerns, includes chapters on depressive disorders, bipolar and related disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma- and stressor-related disorders, and gender dysphoria. In terms of presenting diagnoses, we list 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, 2011). Readers will note that this is the only section in which other specified and unspecified diagnoses are listed.

Part Three, Changes and Implications Involving Addictive, Impulse-Control, and Specific Behavior-Related Concerns, includes chapters focused on behavioral diagnoses such as substance-related and addictive disorders; disruptive, impulse-control, and conduct disorders; personality disorders; and specific behavioral disruptions consisting of feeding and eating, specific eating disorders, elimination, sleep-wake, sexual dysfunction, and paraphilic disorders. Similar to the disorders found in Part Two, counselors are often exposed to the disorders listed in Part Three in their 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 Four, Changes and Implications Involving Diagnoses Commonly Made by Other Professionals, includes chapters focused on neurodevelopmental and neurocognitive, schizophrenia spectrum and other psychotic, dissociative, and somatic and related 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 they 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.

In addition to this *Learning Companion*, ACA and APA provide resources for understanding and using the *DSM-5-TR*. These resources include *Counseling Today's* online's article "What's New With the *DSM-5-TR*?" (Norton, 2022). Although APA resources focus more on the medical model and are less wellness oriented than those provided by counseling organizations, counselors may find the *DSM-5-TR Clinical Cases* (Barnhill, 2023) useful, as well as the *DSM-5 Handbook of Differential Diagnosis* (First, 2022). APA (n.d.) also provides fact sheets and online assessment measures specifically for the *DSM-5* and *DSM-5-TR*.

Questions for Consideration

1. Why do counselors care about diagnosis?
2. What are the major differences between counseling and psychiatry?
3. What do you want to know about the *DSM-5-TR*?

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Chapter 2

Structural and Philosophical Changes to the *DSM:* A Historical Overview

The *DSM-5-TR* (APA, 2022b) is intended to provide additional clarity and guidance for the diagnosis and treatment of mental disorders but does not represent a major revision of the *DSM-5* (APA, 2013a). As outlined in the previous chapter, the *DSM-5-TR* includes some minor changes, corrections, and updates but, with few exceptions, these changes do not represent a significant departure from what was published previously. However, publication of the *DSM-5* marked considerable structural and philosophical changes to diagnostic nosology. These changes are both evident in the current text revision and will continue to be evident in future iterations of the manual. As such, in this chapter, we provide counselors with a general history of the *DSM* and highlight major structural and philosophical modifications first introduced with the release of the *DSM-5*. We present these changes, both in this chapter and throughout the *Learning Companion*, because these modifications represent a major shift in the way in which the manual was organized, including grouping disorders into different chapters based on their common features or etiology, as well as significant philosophical changes that present a more dimensional and contextual approach to diagnostic assessment. To help readers better understand the impact of these changes and the philosophy behind these revisions, we begin with a brief description of the historical background and evolution of the *DSM*. We then provide a deeper look at changes from the *DSM-IV-TR* (APA, 2000) to the *DSM-5* (APA, 2013a) and conclude with information regarding how these changes may influence future iterations.

History of the *DSM*

The original *DSM*, published by 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 *psychophysiological 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 emphasized a medical, rather than psychosocial, model for mental health treatment (APA, 1980; Wilson, 1993). Unlike psychosocial models, which recognize the interplay of psychological and social factors in the development and experience of physical and mental health problems, medical models view illness and disease as physical problems that can be diagnosed and treated through biomedical interventions. Psychosocial models take into account an individual's personal experiences, relationships, social circumstances, and cultural context in addition to biological factors. This model views health and illness as being shaped by a complex array of biological, psychological, and social factors, and that effective treatment should address all these factors. Clearly a profound reframing of diagnostic assessment, adoption of a medical model to classify mental illness represented a clear follow-through on previous attempts to separate the *DSM* from psychoanalytic origins. Supporters claimed "theoretical neutrality" (Maser et al., 1991, p. 271) of the *DSM-III*. 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).

Fueled by the emergence of managed care and the rise of psychopharmacology, publication of the *DSM-III* resulted in widespread acceptance of the medical model (Hansen, 2014). 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, mental health professionals 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)