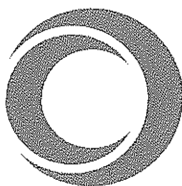

AMERICAN COUNSELING ASSOCIATION

April 16, 2010

David J. Kupfer, M.D.
Chair, DSM-5 Task Force
3811 Ohara Street
Pittsburgh, PA 15213-2593

Dear Dr. Kupfer,

I am sending this letter on behalf of the 43,000 members of the American Counseling Association, the largest association for professional counselors in the United States. As you may know, professional counselors have a master's or doctoral degree in counseling and utilize the *Diagnostic and Statistical Manual of Mental Disorders* as an integral part of our work. As such, ACA appreciates the opportunity to provide feedback on the proposed draft revisions to DSM disorders and criteria. Our comments focus on five areas of particular importance to professional counselors: applicability across all mental health professions, gender and culture, organization of the DSM-5 multiaxial system, lowering of diagnostic thresholds and combining diagnoses, and dimensional assessments.

Applicability Across All Mental Health Professions

Dr. David Kupfer, Chair of the DSM Task Force, stated in a February 10, 2010 APA news release that, "The process for developing the DSM-5 continues to be deliberative, thoughtful and inclusive.... APA is committed to developing a manual that is both based on the best science available and useful to clinicians and researchers." While ACA welcomes the unprecedented openness of the DSM revision process and the opportunity to comment on the work of the task force and its study groups, we are concerned about the minimal extent to which clinical utility has been explored for clinicians who are not psychiatrists. Components of clinical utility include appropriateness, accessibility (ease of use), practicability, and acceptability (Smart, 2006); and reliability, predictive value, and specific clinical implications (Walsh, 2007). While the literature reveals some empirical work on these components, the "users" have been limited to psychiatrists and medical interns. Missing are clinical utility studies with non-medical mental health professionals. It is assumed that when diagnostic criteria are user-friendly, the likelihood and accuracy of usage are increased, clinical decision making is improved, and clients are better served. These assumptions need to be addressed by empirical studies (First et al., 2004) and/or by expert consensus. Therefore, the American Counseling Association strongly suggests that the task force examine usage patterns of clinicians across educational levels (i.e., master's and doctoral) and across disciplines (e.g., professional counselors, social workers, psychologists, and marriage & family therapists).

Gender and Culture

Culture and gender play an important role in mental health, yet are rarely mentioned in the proposed revisions for the DSM-5. ACA members are concerned that the mental health issues of African, Latin, Asian, and Indigenous Americans as well as those of recent immigrants, LGBT individuals, the aging population, individuals with disabilities, and other marginalized populations will continue to be misdiagnosed, underdiagnosed, or ignored with the proposed classification system. As an example, a female client who has been the victim of repeated sexual harassment at work may present with symptoms of depression, anxiety, and/or other disorders. The etiology of the symptoms is sociopolitical/cultural

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and/or historical, yet the client will be diagnosed with pathology. We request that the DSM-5 integrate gender and cultural issues across disorders and criteria.

Organization of the Multiaxial System

Combining Axes I, II, and III as proposed would essentially commingle physical and mental conditions. This creates the potential to dilute the focus of each type of disorder and create confusion over comorbid conditions such as Major Depressive Disorder, Obstructive Sleep Apnea, and Mood Disorder Due to a General Medical Condition. Furthermore, treatment focus could be diminished due to an undisciplined compilation of disorders. Knowledge gained from state (Axis I) and trait (Axis II) characteristics would be lost. The methodology for a hierarchical listing of most to least significant disorders has not been explained and would inevitably cause interdisciplinary disagreements. The collapse of Axes I–III appears to medicalize mental health, rather than recognize the unique aspects and treatment requirements of mental health problems. Because of the significant ramifications discussed in this section, we request that specific information be provided about how the combining of Axes I, II, and III will be organized and that comment be allowed after this information is provided. We also request additional specific information on the standardization of Axes IV and V and that comment also be allowed after this additional information is provided.

Lowering Diagnostic Thresholds and Combining Diagnoses

The proposed DSM-5 revisions trend toward lowering diagnostic thresholds and combining diagnoses. Although ACA is encouraged that this may add some clarity and an ability to categorize some symptoms that have otherwise fallen under the NOS category or caused clinicians to use adult diagnoses in identification of symptoms in children, we recommend more clarity of the boundaries between specific mental disorders and normal psychological functioning. We are concerned that without this clarification, the lowering of diagnostic thresholds may increase false positives or provide questionable indicators of future diagnoses.

As an example of lowered diagnostic thresholds, the diagnosis of Substance-Use Disorders is proposed to take the place of Substance Abuse and Substance Dependence. An individual will need only two symptoms to meet the criteria for this new diagnosis. A second example is that Major Depressive Disorder no longer will exclude bereavement. In reference to combining diagnoses, Autism Spectrum Disorder is now proposed to include Pervasive Developmental Disorder and Asperger's Disorder. We have concerns that professional counselors and other mental health professionals will have difficulty clarifying the uniqueness of the disorder and the concomitant specialized interventions and/or accommodations that are necessary. Other diagnoses that ACA members have expressed concerns about include Binge-Eating Disorder, Mixed Anxiety Depression, Mild Neurocognitive Disorder, Hypersexual Disorder, Major Depressive Disorder, Psychosis Risk Syndrome, Nonsuicidal Self-Injury, Pathological Gambling, and Paraphilic Coercive Disorder.

Dimensional Assessments

Dimensional assessments are being proposed for inclusion within the existing categorical system of the DSM-5. The stated purpose is to provide additional information to assist clinicians with assessment, treatment planning, and treatment monitoring. Professional counselors have long documented limitations to the purely categorical approach to diagnostic classification. The current categorical system encourages counselors to look for client behaviors that fit solely within the diagnostic structure (Ivey & Ivey, 1998; Malik & Beutler, 2002; White, 2002), focuses little on clients' contextual factors (Eriksen & Kress, 2006; Marecek, 1993), and minimizes the uniqueness of individuals (Denton, 1989). Furthermore, low clinical validity, high use of NOS diagnoses, and high comorbidity have been widely documented (Widiger & Samuel, 2005).

As such, we support attempts to improve the quality of diagnosis through the use of dimensional assessments. However, we suggest that APA considers the following: Dimensional assessments must have clinical utility to practitioners across all mental health professions and at all levels (e.g., master's, doctoral), any dimensional system must integrate with existing categorical diagnoses, and dimensional measures must be thoroughly tested and show strong psychometric properties.

Summary

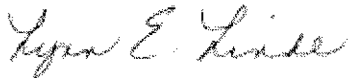
Thank you once again for providing the American Counseling Association the opportunity to provide feedback on the DSM-5 draft revisions. We appreciate the openness of the revision process and your efforts to advance the diagnoses of mental disorders. We hope that our feedback has been constructive and that the following six recommendations made in the body of this letter are helpful:

- That the DSM-5 focuses on clinical utility across mental health disciplines.
- That the DSM-5 integrates gender and cultural issues across disorders and criteria.
- That the DSM-5 Task Force provides specific information about the multiaxial system reorganization and that further comment be allowed after this information is provided.
- That the DSM-5 Task Force clarifies the boundaries between specific mental disorders and normal psychological functioning.
- That efforts to combine diagnoses not result in an increased difficulty in determining specialized accommodations.
- That dimensional assessments have utility across mental health disciplines, integrate with existing categorical diagnoses, and provide strong psychometric properties.

On a closing note, I would like to reflect on APA's stated goal of an open and inclusive process for the development of the DSM-5. In considering this goal, it is clear that APA has involved a variety of professionals within the psychiatric community but has been less inclusive of other mental health disciplines. In addition, while the APA DSM-5 website states that the American Psychiatric Association has conducted numerous DSM-5 presentations at conferences and university medical centers, conference audiences have primarily been medical professionals. None of the presentations listed on the DSM-5 website were made at conferences for other mental health professions that utilize the DSM, such as professional counseling and social work.

The American Counseling Association has expressed a willingness to participate in the development of the DSM-5; however, we have been excluded from this process repeatedly without explanation. It is essential to involve us in this process because we provide a unique perspective. Because of the frequency and duration of counseling appointments, clients/patients may share information with a counselor that is essential to diagnosis and assessment that they do not share with their psychiatrist. As such, ACA requests that we be included in both the field testing process and the dissemination of information to be adequately prepared for the final feedback opportunity in 2011.

Sincerely,



Lynn E. Linde, Ed.D.
ACA President

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Cc: Darrel A. Regier, M.D., M.P.H., DSM-5 Task Force Vice-Chair
Alan F. Schatzberg, M.D., APA President
Carol A. Bernstein, M.D, APA President-Elect
James H. Scully Jr., M.D., APA Chief Executive Officer & Medical Director
Beth Casteel, APA Office of Communications and Public Affairs
Jaime Valora, APA Office of Communications and Public Affairs