

Practitioner Perspective

A Conversation on DSM-5 and its Usefulness in Counselling and Psychotherapy

By Eugene McHugh



health. Indeed, one could argue that bad emotional health leads to mental health issues and many of the classifications in DSM.

Many therapists already use assessment tools in their practice (eg. Clinical Outcome in Routine Evaluation (CORE)) and find this useful as a research tool and for tracking a client's progress over their time in therapy. To be clear, I come from a humanistic and integrative background before I pose the following question.

What is the resistance of our profession to using the DSM-5 or the World Health Organisation's ICD10 (International Classification of Mental And Behavioural Disorders, 10th Revision) as a useful resource? Further, what would be the pros and cons of embracing a tool that is internationally used and recognised by the medical profession and the insurance industry?

A Brief History of the DSM

The DSM is on its fifth revision now. Its inception in 1952 by the Surgeon General was in response to armed forces returning from World War II. It was originally called "Medical 203" and due to the involvement of the American Psychological Association (APA) was renamed as DSM. The original DSM listed 106 conditions over 103 pages. The second edition appeared in 1968 and was

While attending the American Counselling Association's Conference in March 2017, among other workshops on cyber security and ethics, I enrolled for presentations on using the DSM-5 (Diagnostic and Statistical Manual Of Mental Disorders 5th Edition) and its instruments of assessment that counsellors can use for clients.

My curiosity was raised by the various views and objections that therapists have around using DSM and ICD 10 including my own. From a personal perspective, I am fully behind the idea of not labelling our clients and in meeting them wherever they are. However, I am curious as to how we might use

the assessment tools to inform ourselves about our clients' lives and in turn support interventions to aid their emotional growth.

It is my view that our therapeutic work centres around emotional health rather than mental health and I consider that emotional health results in good mental

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increased to 184 conditions over 134 pages. Due to various issues around language and certain conditions it went through six reprints with the last appearing in 1974. There was an attempt to bring the DSM into line with the ICD which was published in 1942, listing mental disorders for the first time. The third edition was published in 1980 with 265 conditions over 494 pages.

In 1987 a revised edition called DSM IIIR was published with 292 conditions over 567 pages. As with previous editions there was problems with some of the diagnoses contained such as homosexuality and premenstrual diagnosis and these conditions were removed. There was also an effort to make the manual more descriptive in tone. DSM IV was published in 1994 listing 297 conditions over 886 pages and the main change was to look at the importance of distress or impairment in social or occupational dysfunction in areas of a persons' life. A revised text edition was published in 2000 called DSM IV TR and it separated the various conditions into classifications such as "clinical", "personality", "intellectual", "medical", "psychosocial" and "environmental". This brings us to 2012 when DSM-5 was approved and then published in 2013.

The Current Version

The work for DSM-5 started in 1999 and took fourteen years to come to fruition and was not without problems. Its purpose was to "increase clinical utility while maintaining continuity with previous editions" (Dailey, F. D., Carman, S. G., Shannon, L. K., & Barrio Minton, C. A. 2014. P3). The initial task of revision was given to seven workgroups looking at nomenclature, neuroscience

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and genetics, developmental, personality, mental disorder, cross cultural, and disability. This was later extended in 2007 to thirteen working groups and resulted in thirteen conferences between 2004 and 2008. There were three public consultations between 2010 and 2012 and 13,000 professionals were involved in commenting on the proposed criteria. The first trials held in 2010 involved 279 clinicians (APA, 2012b, 2012c), and the second trial involved small group practices including licensed counsellors in private practice. The American Counselling Association (ACA) played an important part as an advocate for the counselling profession during the drafting of the manual. The ACA had five areas of concern on behalf of counsellors,

1. Applicability across mental health professions
2. Gender and culture
3. Organisation of the multi-axial system
4. The lowering of diagnostic thresholds and the combination of diagnosis
5. The use of dimensional assessments

ACA expressed their concern about the validity and credibility

of the manual and submitted a prioritised list of issues. Sections of the APA also expressed their concerns. The result was major structural and philosophical changes in how DSM-5 was presented. It included ICD-9-CM (Clinical Modification) and ICD-10-CM codes to cater for billing in the USA at the mandate of the US Department of Health.

Multi-axial versus Non-axial

The most significant change to the manual was the removal of the multi-axial system. Dailey, et al state:

Dropping the multi-axial system confirms what counsellors from a wellness perspective have been claiming for decades – that differentiation among emotional, behavioural, physiological, psychosocial and contextual factors is misleading and conveys a message that mental illness is unrelated to physical, biological and medical problems (2014, P13).

They suggest that assessments need to be more holistic so that diagnosis is not just a simple listing of codes. Counsellors can add in other subjective information to the codes, but it is anticipated that there could be difficulties that may arise in the understanding and interpretation within multi-disciplinary teams. How the chapters were organised has also changed with DSM-5. The listing is now based on a developmental or lifespan approach. Dailey et al, suggest that, the change of listing from 'specified disorder' to 'unspecified disorder' allows the clinician not to specify a particular disorder which supports the dimensional aspect of the client. They state that "this

change reflects the philosophical assumption that mental health disorders are medical conditions” (2014, P.15).

Personal Viewpoint

I would argue coming from a body perspective, that there is a differentiation between Emotional Health and Mental Health where the former is a ‘dis-ease’ and the latter is a physical ‘disease’ within the client. The latter may be caused by long-term emotional issues impacted by the stress response within the autonomic nervous system and / or genetic issues.

Centrally, I believe in the clients’ ability to self-heal and to resolve emotional issues using their own resources with the support of a good therapeutic relationship. I do not believe it is good to provide a label for the client on which to hang their coat and which may prevent them from forming that self-belief in their own strengths. I do wish however to look at using the DSM as an assessment tool for ourselves and as a communication tool with other professionals such as:

- Medical practitioners
- Insurance companies
- Employee Assistance Providers (EAP)
- Psychiatric services
- Researchers

In private practice, therapists may find that insurance companies or agencies require DSM criteria to process payments for services provided. I am putting forward the proposal that as a profession, it is in our best interest to become proficient in the use of the DSM manual when we are in contact with other professions (such as the above) when discussing the treatment of our clients, should

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it be necessary. To be abundantly clear, I am not proposing that DSM criteria are discussed with clients, it is about being more proficient in the use of an internationally recognised tool when in discussion with other professionals and agencies. It is my belief that it is essential that the therapist is trained to consider themselves competent in the use of the manual.

Issues for Counsellors

I can understand how this labelling can present a problem for anybody coming from a person centred or humanistic and integrative perspective. One takes the client “as they are wherever they are” and using theoretical maps, one makes a hypothesis to assist and support the client in the challenge that they undertake in resolving their presenting issues. I consider that once the client walks through my door or makes an initial phonecall, I am making an assessment as a human being. One observes and judges their gait, dress, appearance, culture, shape, facial expressions, mannerisms and tone of voice. Palmer & Dryden (1995, P. 19) suggest that there are certain questions that the therapist should keep in mind while doing an assessment, some of these are listed below:

- Is there evidence of depression, or suicidal / homicidal tendencies?
- What appear to be important antecedent factors?
- Are there clear indications or contra-indications for the adoption of a particular therapeutic style?

One can see that these might not be considered as person centred questions and more from the medical model. They form, however, an important part of our hypothesis and decision making process for the client. In addition, the reality for many counsellors that may be engaged with national (eg. National Counselling Service (NCS) and Counselling In Primary Care (IPC)) and private agencies (eg. EAP providers) is that clinical assessment is a critical part of the work whether using Beck’s Depression Scale or CORE OM. Corey (1996) states “the purpose of diagnosis in counselling and psychotherapy is to identify disruptions in a client’s present behaviour and lifestyle”. He goes on: “a diagnosis is not a final category; rather, it provides a working hypothesis that guides the practitioner ...” (p. 68). Therefore, assessment is an important part of a client intake and forms the hypothesis for client focus, goals, and possible duration. In private practice, this may be an informal or formal process and ethically is a necessary part of the intake as it may involve a therapist

having to consider a referral to another professional better placed to support the client. One could certainly argue that as a therapist I am already making a diagnosis, albeit for my own use, in establishing a working hypothesis for the benefit of the client. Reeves writes, "... as counsellors, we can acknowledge these early assessments and 'bracket' them in such a way that they can inform our thinking, but not direct it" (2008, p63).

Assessment questions need not be a long list of strict queries, but can be integrated at an early stage to start to understand what is going on for the client. Reeves proposes:

That these impersonal questions can be quickly transformed into a flowing and respectful dialogue, that not only provides the counsellor and the client with a clear overview of difficulties and problems, but can help the client to feel listened to and taken seriously" (2008, p.66).

It may be understanding the medication that the client is on and how it impacts on their daily lives. It may be understanding their experience a psychological service which they attend. I wonder how many therapists have a copy of MIMs in their office to understand the effects of certain medications on their clients as these can impact on the therapeutic process and the relationship. Corey (1996, p.69) quotes Brammer, Shostrom, & Abrego, (1989) as proposing that therapists, "simultaneously understand diagnostically and therapeutically" (p.148).

I accept that while all the aforementioned can be argued as not being person-centred, professionally it is something that one does for

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the benefit of the client. As Reeves suggests, it does not direct how it is brought to the client, but the therapist does use it to understand the clients experience. This will help the therapist in accompanying the client in their self-discovery, which can be argued is a person centred effort.

Relationship Model versus Medical Model

As stated more than once, I absolutely agree that it is the supporting and honest therapeutic relationship that is at the core of the work that our profession provides. However, as a therapist I have four years of both objective and subjective training and practice in how to accomplish this non-judgemental, non-aggressive and supportive work for the client. A student spends the first two years, in most cases, building this capability to sit with a client. It is the training in practical skills and techniques, and the depth of personal reflection that equips professionals to sit with a client no matter where they are. That is the difference between the counselling profession and any other profession in the mental health field.

This practical competence sets the counsellor apart to deliver the service he or she provides. This is, for me, the place where other professions divide from the

psychotherapeutic relationship place and where I see the need for the counselling profession to take on a responsibility to understand other professions so that we can engage with their language for them to understand our language. Corey (1996) quotes Goldfried and Castonguay (1992) as they predict the future directions for therapy: "it would not surprise us if we saw future generations of therapists choosing to be trained in one particular orientation, while at the same time showing a greater openness toward the theoretical, clinical and empirical approaches" (p.5).

So, should professional counsellors embrace a medical approach in order to aid our work? While discussing mental disorder and a lack of empathy in primary carers and the later pathological developments, Ute Binder in Thorne and Lambers (2006) proposes that, "A knowledge of pathogenic factors makes it possible to activate constructive, healing developmental processes through a specific therapeutic empathic understanding of the disorder" (p.216).

Let's look at a common condition that probably counts for a large percentage as a presenting condition: "general anxiety disorder". DSM-5 tells us that excessive worry or anxiety about a number of events is a key feature of the issue over most days within a 6-month window. It suggests that clients are keyed up or fatigued with muscle tension and sleep disturbance etc. It advises the therapist to consider cultural factors and whether there are issues around PTSD, bipolar, and psychotic disorders. It gives a list of questions that may clarify the issue and other factors that may impact on the client (Dailey et al, 2014. p. 81-85). This useful information may give a good understanding of what

is going on for the client and may provide guidance in what questions may be offered in the assessment. In the DSM-5 manual itself anxiety is covered from p.189-233, thus providing a useful reference for what might be present.

Another example is “substance related and addictive disorders” which gives a definition for addiction and suggests the criteria we might consider while doing the assessment. It also offers various types of substance misuse for consideration (Dailey, et al., p.149-164). Again, in DSM-5, addictive related disorders guidance and information is provided from p.481-590 providing valuable insight into a client’s world. These examples from the DSM are offered as they are common in most practices. The manual gives the therapist the ability to inform themselves in making a useful hypothesis so that the client can be supported in the healing process.

Conclusion

As discussed initially the information is for the therapist’s benefit, which in turn supports the client. In embracing this tool in dealing with other professionals, it facilitates a clear and common language, especially where as a professional one is looking for recognition from insurance companies and national health providers. The result may be a more integrated multi-disciplinary approach for the client. This is to the benefit of the individual that presents looking for professional support to deal with an issue which is causing them distress. It is my view that, as professionals, it is incumbent on us to inform ourselves on best practice. The use of a tool such as DSM-5 supports our profession in this regard and facilitates a better engagement with the mental

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health industry. Finally, it is useful to consider that in the USA and in Australia, all counsellors are trained in the use of DSM. Philip Armstrong CEO of the Australian Counselling Association believes that it is an important part of their conversation when they obtained recognition as professionals by the Australian authorities. On balance, I believe that with careful use, DSM-5 is a worthwhile tool in Counselling and Psychotherapy. ☺

Glossary of Terms

Becks Depression Scale – Created by Arron T Beck, 21 Questions with Score of 0 to 3.

CORE – Clinical Outcome Routine Evaluation, 34 Questions scored in 4 categories

DSM – Diagnostic Statistical Manual
EAP Schemes – Employee Assistance Programmes

ICD – International Classification of Disorders

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Eugene McHugh

Eugene Mc Hugh, MIACP, EACac. ACA. B.A.(Hons) Integrative Counselling and Psychotherapy is trained in Body Psychotherapy, Addiction, Mindfulness, Supervision and PTSD (Babette Rotschild). He is a lecturer in Dublin Business School on the B.A.(Hons) in Counselling and Psychotherapy. He is in private practice as owner of Wicklow Counselling Service in Bray, Co Wicklow and has delivered training to various bodies including Rathdown School, Aware, Church of Ireland Theological Institute and Hakomi Loving Presence. He has also served for four years on the IACP Board of Directors as Leas Cathaoirleach and Cathaoirleach.

Eugene can be contacted at info@wicklowcounsellingservice.ie