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Counselors' Perceptions of Training, Theoretical Orientation, Cultural and Gender Bias, and Use  
of the *Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision*

A Dissertation

Submitted to the Graduate Faculty of the  
University of New Orleans  
in partial fulfillment of the  
requirements for the degree of

Doctor of Philosophy  
in  
Counselor Education

by

Micah Patureau-Hatchett

B.A., University of New Orleans, 1998  
M.Ed., University of New Orleans, 2001

August 2008

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## **DEDICATION**

I am proud to dedicate this dissertation to my parents, Gene and Bridgid Mearns, my husband, Jesse Hatchett, and my son, Brice. All of you inspire me, teach me, love me, encourage me, push me to carry on, count my blessings, give to others, and believe in myself and my abilities. I love you all without measure.

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To my son, Brice—your birth has completed me as a person and motivated me to complete this journey. I am a better person because of you, and I plan to instill a love of learning in you like it was instilled in me.

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## Abstract

Counselor educators and counseling practitioners today reflect the future direction of the counseling profession; therefore, their opinions are important when discussing how professional counselors can reconcile the basic philosophies of humanistic counseling with the practical advantages and ethical and philosophical disadvantages that appear to be coexistent when discussing the diagnosis of clients and the *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM)*. This study sought to provide a reflective and concise description of the current perceptions of licensed professional counselors in reference to their training, their practice, and their dispositions about diagnosis and utilization of the *DSM* despite its theoretical grounding in the medical model and its chronic problems with gender and cultural bias—all in direct opposition to counseling’s humanistic, multicultural model of practice.

Results of this study suggested that more training in *DSM*/diagnosis led to participants’ higher perception of their ability to diagnose and utilize the *DSM*; however, participants’ perceptions were split on whether or not training should include psychopharmacology. Results also suggested that LPCs most frequently occurring ethical dilemma in relation to diagnosis involved the reimbursement requirements of insurance/managed care companies; however, they strongly disagreed that diagnosing clients conflicted with their counseling professional identity. Participants strongly agreed that they were multiculturally competent; however, those participants who indicated that they diagnose using a multicultural or wellness perspective did not agree that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse and female clients accurately.

Keywords: *DSM*; diagnosis; counseling; LPC

## CHAPTER ONE

### INTRODUCTION

Licensed professional counselors (LPCs) must be educated and conversant in the areas of assessment, human behavior, and diagnosis (Eriksen & Kress, 2006; Ivey & Ivey, 1999; Seligman, 1999). This knowledge is important not only for those who work in mental health specialties of counseling; school counselors, for example, are often asked to either diagnose or at the least recognize behaviors that can indicate a need for counseling intervention (Geroski, Rodgers, & Breen, 1997; Hinkle, 1999). Counselors also are expected to be able to communicate and consult with an array of professionals involved in the health care of others (Geroski et al., 1997; Remley & Herlihy, 2007), and be qualified as providers for some type of healthcare insurance which requires a diagnosis from the practitioner in order to be reimbursed for their services (Hinkle; Remley & Herlihy).

The Council for the Accreditation of Counselor Education and Related Programs (CACREP) requires counseling graduates to be able to demonstrate knowledge in abnormal human behavior (CACREP, 2001), and the American Counseling Association (ACA) references a need for knowledge of “pathology” in its definition of counseling (ACA, 1997). ACA also provides counselors with a detailed subsection of ethical guidelines pertaining to the practice of diagnosis (*ACA Code of Ethics*, Section E.5, 2005).

Preparing counselors-in-training to understand the nature of abnormal behavior, therefore, must include a thorough examination of the *Diagnostic and Statistical Manual of Mental Disorders-IV-Text Revision* (American Psychiatric Association, 2000 [APA]; referred to throughout this document as *DSM*), the fundamental tool for assigning a mental health diagnosis in the United States. The section entitled *Cautionary Statement* in the beginning of the manual

states, “The purpose of the *DSM-IV* is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat people with various mental disorders” (p. xxxvii).

The requirement by both CACREP and ACA that counselor trainees be proficient in the subject of mental behavioral disorders appears to indicate that the general profession of counseling endorses and utilizes the practice of diagnosing clients. Despite this endorsement, the philosophical paradigms of counseling remain developmental and wellness-oriented, and thus somewhat incongruent with the philosophical paradigms used to develop the *DSM* (Remley & Herlihy, 2007).

### **The Problem in Perspective**

Many counselors identify with interventions and theories of human behavior that promote the premise that humans are capable of growth and change (Remley & Herlihy, 2007). However, the *DSM* has long been identified by counselors as a medically modeled tool that can hamper the ability of clients to change and grow by assigning them as having an “illness” (Eriksen & Kress, 2005; Ivey & Ivey, 1999; Remley & Herlihy). Despite the methodology and the philosophical differences, the *DSM* prevails in modern healthcare and is considered a necessary tool of the trade for many counselors (Ivey & Ivey; Mead, Hohenshil & Singh, 1997; Seligman, 1999).

As the counseling profession strives to carve out an identity distinct from other mental health professions, the advantages and disadvantages of training counselors to diagnose continue to be discussed in the literature with various points of view on how intense the training should be (see Hansen, 2003; Seligman, 1999). There is an abundance of literature that addresses the limitations of the *DSM* as it is applied to counseling and how those limitations are viewed from a developmentally-oriented perspective (e.g., Eriksen & Kress, 2006; Ivey & Ivey, 1999).

Plentiful, as well, are the published opinions of mental health professionals about how to more selectively scrutinize the *DSM* in a multicultural context appropriate to the client (Herlihy & Watson, 2003, Velásquez, Johnson, & Brown-Cheatham, 1993). Also discussed in depth in the literature is the importance in this relatively new profession that its members espouse a united philosophy that encompasses all specialties of counseling for a strong professional (and thus distinct and more competitive) identity to be established (Hansen, 2003; Remley & Herlihy, 2007). Literature exists that explores ethical challenges such as misdiagnosis and managed care (Braun & Cox, 2005; Remley & Herlihy), and how frequently these challenges occur (Mead, Hohenshil, & Singh, 1997). Ethical dilemmas associated with patient safety and welfare with respect to diagnosis are also present in the literature (Remley & Herlihy).

What appeared to be lacking in the current literature was a clear, measured consensus of opinion from the licensed professionals who engage in diagnosis about how they perceive the adequacy of their training to diagnose. What also appeared to be underrepresented in the literature was information pertaining to their ethical struggles in reconciling their counseling theoretical orientation and the contrasting premises contained in the *DSM*. Missing from the current counseling literature, too, was a discussion whether and how counselors today are reconciling the cultural milieu of the client with the assumptions made in the *DSM* about the distribution of disease over cultural and gender-specific lines.

### **Conceptual Framework**

The conceptual framework for my study was built around a study published in 1997 by Mead, Hohenshil, and Singh. Their landmark study gauged the practices of Certified Clinical Mental Health Counselors (CMHCs) in using the *DSM*. This study is still widely cited in the literature to establish the utility of the *DSM* in the counseling profession.

The study's results indicated a broad acceptance of the *DSM-III* system (the study actually was conducted a few years prior to publication of the *DSM-IV*—however, the authors assumed the results were still applicable to the *DSM-IV*) by the CMHC community (Mead et al., 1997). Fifty-three percent of the respondents reported that they would use the *DSM* even if they were not required to do so, and a majority believed that they were skilled in its use (Mead et al.). When asked about the advantages and disadvantages of the tool, the highest rated advantages were associated with billing, while the highest rated disadvantages were those associated with bias and labeling of clients. Seventy-one percent of respondents agreed with the assertion that the advantages of using the *DSM* outweighed the disadvantages (Mead et al.). Mead et al. also reported that CMHCs were able to identify clinical usefulness of the *DSM* in communication and case conceptualization.

Although not directly questioned about their own actions, more than half of the CMHCs surveyed were aware of instances of intentional misdiagnosis. Over 70% of the respondents reported knowing about at least one occasion of under-diagnosing—intentionally giving a client a less severe diagnosis—and over 60% of the respondents reported knowledge of at least one instance of over-diagnosing—intentionally giving a client a more serious diagnosis (Mead et al., 1997).

Mead et al. (1997) concluded that the CMHCs who participated in the study rated the possibility of negative labeling effects on the client as a more important disadvantage of the *DSM* than any difficulty using or understanding the manual. Mead et al. attributed that result to CMHCs at the time having better training in its use than they had historically, and to a blossoming of dedication to the profession that was occurring. Mead et al. called for further training in the *DSM* system to eradicate the practice of misdiagnosis. They feared this practice

would erode the credibility of not only the counseling profession, but of all other helping professions which encounter this illegal and unethical practice.

Despite the brief mention of the possible rise of the dedication to counseling, Mead et al. (1997) did not examine how the CMHCs perceived the theoretical incongruence between the medically modeled *DSM* and the developmentally modeled paradigms of counselors, nor did they explore the participants' diagnostic training.

This dissertation study built on the work of Mead et al. (1997) by further researching counselors' perceptions and attitudes in reference to ethical issues, training, and cultural and gender bias. Hansen (2003) appeared to be concerned about the over-identification of neophyte counselors with the medical model, and called for more research into counselor training in diagnosis and how that training affects counselors' internalization of the wellness vs. the medical model. Mead et al. called for further research into training issues to alleviate the ethical problem of misdiagnosis. Herlihy, Watson, and Patureau-Hatchett (2008) described a pattern of cultural insensitivity in the *DSM* and ethical considerations that arise from its use. Braun and Cox (2005) also echoed the importance of further study into ethical dilemmas such as over- and under-diagnosis when working with managed care companies.

This study differed from Mead et al.'s (1997) study, in that the study targeted LPCs (as opposed to CMHCs whose certification does not necessarily require licensure) and their dispositions and perceptions of cultural and gender-specific bias in the *DSM*; and with what theoretical orientation they identified in contrast to the medical model embraced by the *DSM-IV-TR*.

### **Purpose of this Study**

This purpose of this research study was to identify LPCs' perceptions of and attitudes toward their theoretical orientation and use of diagnosis and the *DSM*; training in diagnosis and using the *DSM*; cultural and gender-specific bias in the *DSM*; and encounters with ethical dilemmas related to diagnosis and the *DSM*.

This study encompassed several variables that often are discussed in the literature as important considerations and limitations for counselors in the process of diagnosis (see Eriksen & Kress, 2006). Absent from the literature is a study of how all of these factors are actually perceived by counseling practitioners today; therefore, the variables of cultural and gender-specific bias, ethical considerations, training, and the impact of theoretical alignment were included in this research study.

### **Research Question**

The general research question addressed in this study is: What are LPCs' perceptions of their preparation to diagnose and use the *DSM*; their perceptions and disposition about cultural and gender-specific bias contained within the *DSM*; their encounters with ethical dilemmas related to diagnosis and the *DSM*; and their perceptions of their ability to adhere to their theoretical orientation while fulfilling a practical need to diagnose clients?

### **Assumptions of the Study**

The first assumption of this study was that a survey instrument must be created, the "LPC Uses and Perceptions of the *DSM-IV-TR*" (UPDSM), and that it is reliable and valid—accurately measuring the perceptions of LPCs on the relevant topics. Another assumption of this study is that the participants answered honestly and accurately and all were currently practicing licensed professional counselors or some equally licensed variant in the state where they practice. This



study assumed that the respondents identifying themselves as counselors had a reliable understanding of the theories and current practice methods in the counseling field, that the respondents graduated from a training program in which diagnosis and/or the *DSM* was taught, and that they were aware of what the *DSM* is and how it is utilized by professional counselors. It is assumed that counselors participating in the study were available and able to answer questions as they are formatted on the internet, and had access to email.

### **Definition of Terms**

The following terms are defined below in order to provide further clarification of terms that are found within this research.

Bias: Defined by Merriam Webster Online (<http://www.merriam-webster.com/dictionary/bias>) as “an inclination of temperament or outlook; especially: a personal and sometimes unreasoned judgment.” Qualified in this study by either the terms “cultural” or “gender-specific,” this term is defined as an expression in both the *DSM* and society to make unnecessary, unfair, or untrue assumptions about non-Eurocentric cultures or women.

Developmental Model/Perspective: A paradigm used in the counseling profession to describe the developmental tasks of life and conflicts experienced as a human being according to one’s age and environmental context as normal and natural (Remley & Herlihy, 2007).

Diagnosis: Defined by Merriam Webster Online as “the art or act of identifying a disease from its signs and symptoms” (<http://www.merriam-webster.com/dictionary/diagnosis>). In this study, this term refers to the process in which a client is given a label to describe a mental disorder as it is named in the *DSM*.

LPC: A licensed professional counselor who has completed the required hours of supervision and experience as a counselor intern and has obtained licensure in the corresponding state. The title of the license may vary according to state.

Medical Model/Perspective: As defined by Remley and Herlihy (2007) and as used in this research study, the medical model is a reactive paradigm practiced in most medical settings in which a helper identifies illness when approached by a patient, diagnoses that illness, and ameliorates the symptoms. This perspective assumes the person asking for help is diminished in some way and is in need of some type of cure (Remley & Herlihy).

Multiculturalism/Multicultural Counseling: A counseling paradigm in which the counselor remains aware of his/her own biases, assumptions, and values; appreciates the world view of the client who is culturally different; and bases therapeutic techniques on consideration of appropriate cultural differences (Sue, Arredondo, & McDavis, 1992).

Wellness Model/Perspective: This term within this study describes the counseling paradigm which encourages practitioners to conceptualize mental health as occurring on a continuum in which the client's adjustment to life ranges from self-actualized to dysfunctional and "life tasks" ranging from family relationships to sexuality are considered to have an influence on the wellness of a person (Myers, Sweeney, & Witmer, 2000).

## CHAPTER TWO

### REVIEW OF THE LITERATURE

The purpose of this chapter is to report on the current literature related to licensed professional counselors' perceptions and experience with diagnosis, conflicting theoretical paradigms, and the *DSM*; diagnostic training issues; cultural and gender-specific bias that may occur within the *DSM*; and ethical dilemmas that can occur as a result of counselors diagnosing clients. This chapter is organized into four subsections—each building on the conceptual framework for examining counselors' perceptions and experiences with diagnosis and using the *DSM*. The first subsection outlines the historical and contemporary literature concerning the relationship between the counseling profession and the practice of diagnosis, and the theoretical conflicts that occur between the two. The second section explores the evolution of the *DSM* as a body of work and influence on the helping professions. The third subsection examines literature regarding professional counselor training in the area of diagnosis, and the fourth subsection presents information pertaining to cultural, gender-specific, and ethical concerns stemming from the use of the *DSM* and the practice of diagnosis.

#### **The Counseling Profession, Diagnosis, and Dogma**

##### *Carl Rogers' Influence on Counseling Dogma*

In the 1940s, before the *DSM* was published, Carl Rogers' publications were influential in shaping the counseling profession's most basic philosophies. He broke away from more traditional practices of clinical psychology which were largely influenced by Sigmund Freud's methods of psychoanalysis and psychosexual theories of human development, and instead espoused what would be referred to as a "nondirective" process of counseling (see Rogers, 1945). This philosophy, in part, stressed the significance of the relationship between counselor

and client, as well as the importance of refraining from imposing any value judgments on the client. Rogers wrote: "...he [the clinician] enters into the therapeutic situation as little as possible and interposes none of his own opinions, diagnoses, evaluations, or suggestions" (p. 279).

Rogers' theories are essential in the basic training of contemporary counselors. Therefore, subscribing to the paradigm of counseling means believing that individuals are capable of growth, development, and change; and that counselors are the facilitators of this change (Fall, Holder, & Marquis, 2003). Conspicuously absent from this paradigm (though not from the language of the ACA's definition of counseling which will be discussed later in this subsection) is any mention of diagnosis, disorder, or taxonomic classification—the core of the *DSM*. Rogers decided not to engage in much debate in the mid-1940s regarding his theories—much to the chagrin of his contemporaries, Frederick Thorne and William A. Hunt, who were proponents of empirically supported directive techniques of psychology.

Frederick Thorne, a prolific writer and researcher in the psychology field, was a supporter in Rogers' time of directive methods of psychotherapy (Hunt, 1948). He criticized Rogers' theories due to their lack of experimental research to support them. He was shocked to see how Rogers' theories went seemingly unopposed and unquestioned without such research—a dangerous precedent to Thorne. Thorne also staunchly believed in the absolute necessity of diagnosis, stating "...the essential prerequisites for any valid system of therapy must include intensive aetiologic and diagnostic studies..." (Thorne, 1948, p. 262).

In 1952, soon after Thorne's criticisms of Rogers' theories, the first edition of the *DSM* was published by the APA, perhaps lending some additional credibility to Thorne's points about the need for classification of mental illness as it was known at the time. Today, the *DSM* is acknowledged as one of the most influential books in the United States in terms of how

diagnoses affect people's lives (Cooper, 2004; Duffy, Gillig, Tureen, & Ybarra, 2002; Eriksen & Kress, 2005; Rogler, 1997).

Despite criticisms due to the lack of empirical research at the time of Rogers' techniques, Thorne and Hunt for the most part agreed with Rogers' assertions regarding the advantages of the nondirective approach when establishing rapport and eliciting the story from the client (Hunt, 1947; Thorne, 1948). However, Thorne emphasized that there is a point at which Rogers' techniques must be put aside and more directive approach be taken in order to move through impasses that may occur when the client is not making sufficient progress in treatment (Thorne). Thorne conducted an admittedly non-scientific experiment wherein Rogers' techniques were used with people diagnosed with various named levels of mental stress. There were a good many instances wherein Rogers' techniques were useful to some degree. However, the techniques were ineffective for some people diagnosed with disorders such as "Psychotic Syndromes" or "Pathological Personality Syndromes" (p. 259) and, in many instances, Rogers' techniques were used to create a sense of trust in the counselor who would then utilize directive techniques with the client.

Since then, Rogers' theories have been empirically validated. Traux et al. (1966) conducted one in a number of research studies to substantiate Rogers' core conditions (genuineness, empathy, and non-possessive warmth) and were able to further the influence of person-centered Rogerian ideas—which continue to prevail in modern psychotherapy.

Such is also the case with William Glasser's Choice Theory. Glasser (2004), a psychiatrist and founder of the William Glasser Institute in 1967, espoused that there is in fact no biological basis for the prescription of medication or of any medical intervention in order to alleviate mentally distressing symptoms, and reiterates that people's suffering occurs as a result

of problems with people's ability to relate to other people. Glasser insisted that only the counselor, in contrast to the psychiatrist, clinical psychologist and clinical social worker, will explain to clients that there is no biological basis for psychiatric medicine, and that the unhappiness one feels is based on his beliefs about human relationships.

It is apparent that the forefathers of the helping professions promulgated a vigorous discussion of the philosophies that underpin the art of helping and fostered the branching off of the counseling profession from psychology and psychiatry. The arrival of the *DSM* during that process seemed to add a tangible system that the nondirective proponents could rail against—a book that was used by the medical profession and began the dominance of the taxonomic system of mental disorders.

#### *The Debate Continues: 1990s-Today*

In 1998, Ivey and Ivey suggested "...that there is no necessary conflict between a developmental and pathological view" (p. 334). They based this assertion on their perspective called Developmental Counseling Therapy (DCT). They insisted that this perspective does not conflict with the *DSM* but instead provides a "...positive developmental approach in conceptualizing client history within a cultural context, understanding client behavior in the here and now of the interview, and using multiple treatment alternatives in a network model of treatment and action. It is postmodernist in perspective in that it deliberately respects past traditions of the helping field and views past (and most present) theory and practice as useful narratives or stories about the helping process" (p. 335).

Ivey and Ivey (1998) firmly believed in the prevalence of developmental issues and not "disorders," and in addition to taking apart the restrictive and disease-centered language of the *DSM*, gave numerous examples of how to reframe client stories and problems in a developmental

perspective and explanations of how Axis I disorders may be a manifestation of an over-reliance on Axis II personality structures. Ivey and Ivey appeared to recognize the importance of the *DSM* in the counseling field; they suggested usage of their techniques backed by their own experience. Their perspective is based on their combined (and impressive) years of experience in the field and their own successes.

Responding to Ivey and Ivey's 1998 article was J. Scott Hinkle (1999), who was troubled by his perception that the Iveys were determined to work against the medical profession and professionals who endorse the *DSM*. He endorsed a collaborative spirit with medical and other mental health professionals to further the wellness of counseling's clientele (Hinkle). Hinkle further asserted that the *DSM* is not written in line with the medical model and that the Iveys appeared to be splitting semantic hairs. He stated: "Mental disorders according to the medical model describe *disease processes*, not people" (p. 477). And "If you are a counselor, the *DSM* may not be a manual of diseases, but simply a description of harmful behaviors, dysfunctions, mental disorders, developmental roadblocks, or whatever one chooses to call them" (p. 477). Hinkle suggested that counselors use developmental postulates as one of many theoretical constructs to help clients with their life functions.

Ivey and Ivey (1999), in response to Hinkle, recounted in more detail their experience with DCT and identified a number of points about which they were in agreement, including the need for communication and cooperation with the medical profession. They concluded that the most glaring areas of disagreement lie in how the developmental theories are applied—the Iveys declared that they can be applied more broadly than Hinkle suggested—that the social system of the client must be accounted for and worked with in conjunction with the client himself/herself (Ivey & Ivey).

Duffy et al. (2002) stated that regardless of the system of thought, conflict arises with the use of the *DSM* both for those who are positivists—believing “...in an independent, external reality that can be apprehended either directly or indirectly through the application of a systematic way of knowing, primarily as the scientific method” (p. 364); and those who are social constructivists—believing “...in the construction of reality, particularly social reality, through the coordination in time and space of people interacting in language and generating consensual agreements about the nature of things and their meanings” (p. 364). The positivists (i.e., Thorne, Skinner) see the biggest problems with the *DSM* in terms of the taxonomy and how and why disorders are categorized, and the social constructionists (e.g., Eriksen & Kress, Ivey & Ivey, Rogers) see the problems in terms of the “...concerns that the dominance of the *DSM* drowns out alternative understandings of behavior that have been deemed pathological” (p. 365). Duffy et al.’s use of the word “dominance” seems to clearly define what the social constructivists today are working to reconcile—the *DSM*’s dominance in the explanation of human behavior.

In 2001, Ginter and Glauser discussed the use of the *DSM* from a developmental/wellness perspective. They recommended that counselors utilize the *DSM* with care, considering the following points: (1) counselors subscribe to the assertion in the *DSM* that it classifies the disease and not the person, (2) diagnosis can evolve as the counseling process evolves, (3) counselors must remain aware of the *DSM*’s limitations, (4) effective treatment is dependent on whether the client is “fully understood” culturally and contextually, (5) being an effective counselor means having sufficient and satisfactory knowledge of the *DSM*, and (6) developmental approaches can “...provide an effective bridge between use of the *DSM* system and the theoretical foundation of counseling” (p. 76).



### *Positions of the Professional Counseling Organizations*

Professional counseling organizations, such as the American Counseling Association (ACA), as well as accrediting organizations such as the Council for the Accreditation of Counseling and Related Educational Programs (CACREP), appear to attempt to respond to both society's and private insurance companies' demands for categorizing and recognizing the need for diagnosis in counseling. The ACA's definition (also adopted by the National Board of Certified Counselors [NBCC]) of counseling is: "The application of mental health, psychological or human development principles, through cognitive, affective, behavioral or systematic intervention strategies, that address wellness, personal growth, or career development, as well as pathology" (ACA website, 2007). The ACA and American Mental Health Counselors Association both require a multicultural approach to diagnosis in their code of ethics (*ACA Code of Ethics*, 2005; *AMHCA Code of Ethics*, 2000).

ACA's definition of counseling includes the prepositional phrase "as well as pathology" at the end of the definition. It stresses developmental paradigms, illustrating the counseling field's ongoing struggle with classifying individuals into a neat, scientific category while at the same time trying to understand the intangible world views and experience of human beings.

### **The Evolution of the DSM**

Hansen (2003) called the *DSM* "iconic" (p. 96), while Rogler (1997) stated, "Very few professional documents compare to the *DSM* in affecting the welfare of countless persons" (p. 9). To understand the importance of the current edition of the *DSM*, it is imperative that the foundation of this influential work as well as the possible changes that may come in future editions be explored.

According to the authors of the *DSM*, the idea for the *DSM* originated from a need in the United States to collect statistical information, and its earliest inceptions were derived for inclusion in the first edition of the American Medical Association's *Standard Classified Nomenclature of Disease*. While the U.S. Army developed more names for disorders to describe the mental distress of men serving in World War II, the World Health Organization (WHO) published the *International Classification of Diseases (ICD)* which picked up much of the nomenclature used by the Army to describe several major mental health conditions. In 1952, a variation of the sixth edition of the *ICD* was introduced as the *Diagnostic and Statistical Manual: Mental Disorders (DSM-I)*. The *DSM-I* was influenced heavily by Adolf Meyer's views on psychobiology, and the word "reaction" was used throughout to describe how the personality responds to biological, psychological and social stressors (APA, 2000, p. xxv).

Despite Stengel's WHO-sponsored commission to revise the *ICD-6* and *ICD-7*, the *ICD-8* and the revised *DSM-II* did not follow his recommendations except to eliminate the term "reaction" (APA, 2000, p. xxv). When it came time for the newest revision of the *ICD*, the *DSM* followed suit and work began on the *DSM-III*, released in 1980, which debuted the multiaxial system and "...a descriptive approach that attempted to be neutral with respect to theories of etiology" (APA, 2000, p. xxvi). This point may be best illustrated when in the 1970s, the APA, responding to intense social scrutiny, revised the *DSM* for its third edition by removing homosexuality as a mental disorder and instead created a classification for those struggling with their self-identification as gay persons (Cooper, 2004). The APA's endeavor to increase the *DSM*'s overall utility for mental health professionals and researchers resulted in them finding more inconsistencies and ambiguity in the third edition, thus work promptly started on the *DSM-*

*III-R* in 1987 (APA, 2000). The *DSM-IV* was released in 1994, and the revised edition of the *DSM-IV*, the *DSM-IV-TR*, was released in 2000.

Today, the *DSM* is presented in a more atheoretical light (Hinkle, 1999). In the introduction section of the *DSM-IV-TR*, the authors take great care not to endorse any particular school of thought by name. However, the authors notably state a somewhat humanistic viewpoint when they point out that the *DSM* does not classify “people,” but rather the “disorders that people have” (APA, 2000, p. xxxi). According to the APA website, the *DSM-V* is scheduled for release in May, 2012 (APA website, n.d.). To this end, professional discussions conducted by groups appointed by the APA are now under way.

In 2002, Kupfer, First, and Regier, along with the APA, published *A Research Agenda for DSM V*; the first published of three anticipated books intended to stimulate research and discussion on issues that the authors believe should be considered for integration into the *DSM-V*. Included in Kupfer et al.’s book are chapters and discussions involving problems with nomenclature, defining mental disorders according to their biological etiology, and cultural factors that influence psychopathology not only in the United States, but worldwide (Kupfer et al.). The anticipated books will explore in depth age, gender, and cultural and spiritual issues affecting diagnosis (APA website, n.d.).

Kupfer et al. (2002) acknowledged problems in the lack of universality of the *DSM* and incompatibility with the *ICD-10*. The authors also identified the broadening group of medical practitioners who are making diagnoses; thus, the “need to operationalize the diagnostic process in nonpsychiatric settings...” (p. 1). The authors also acknowledged weak methods in classifying some of the in the disorders—causing the criticism of pathologizing common life experiences (Kupfer et al.). Kupfer et al. discussed the importance of further clarifying the definition of

mental disorder to encompass at least one universal principle-that it will clearly mean the inclusion or exclusion of a classification from the *DSM-V*. They described what they see as society's growing discomfort with the "...progressive medicalization of all problem behaviors and relationships" (p. 3).

The above acknowledgements by Kupfer et al. (2002), a group of people wielding influence over the content of the *DSM-V*, validate an effort to respond to the growing importance and demands by society similar to their colleagues in the 1970s. Kupfer et al. also appear to acknowledge changes in the healthcare industry by considering issues regarding the continued reliability and credibility of the *DSM* system. Whether or not it will live up to these aspirations will be determined in the years to come. The APA calls the 18-year gap between *DSM-IV* and *DSM-V* "...the most scientifically productive era in the history of psychiatry" (APA website, n.d.)

### **Diagnostic Training of Counselors**

CACREP is the accreditation board for counselor education programs in the United States and British Columbia (CACREP website, 2007). CACREP releases sets of standards; e.g., curriculum and supervision requirements that must be met by university counselor training programs to qualify for accreditation. The standards vary slightly depending on the specialty concentration(s) offered by the university. CACREP standards are used to formulate test questions in NBCC exams, which illustrates the influence CACREP standards have on the training of counselors (CACREP website, 2007). The introduction section of CACREP's 2001 Standards acknowledges the evolution of the counseling profession as it responds to and attempts to anticipate changes in society both in America and abroad.

Specific in the CACREP curriculum standards is language outlining the course requirements to satisfy student proficiency in the area of human growth and development. The

standard states that students should be able to demonstrate an understanding of both “abnormal behavior” and “pathology (CACREP standards section K.3.c., 2001). In the same section, the standards require an understanding of “development over the life-span.” The word “diagnosis” is absent from this standard, yet the practice of diagnosis is taught in virtually every counseling program. There is scant literature suggesting that counselors should not receive some education in diagnosis; however, the degree to which it is taught, how it affects counselor identity, and how the topic should be presented to preserve counseling developmental perspectives within courses designed to teach diagnosis, are all discussed at length in the literature.

The ACA’s inclusion of the word “pathology” in their definition of counseling, as well as CACREP’s clear but generic standard for counselor training programs, may contribute to the dilemma that training bodies face. How can a program stress both a humanistic, developmental perspective of human growth yet at the same time recognize the need for understanding medically modeled concepts, and preserve a distinct counselor identity? Scholars have published opinions on this conflict and some have offered suggestions for ways counselor educators can rectify this dilemma while still adhering to CACREP and ACA standards.

Absent from the literature are arguments that CACREP or ACA are wrong or ill-informed in their requirements for training. However, few have studied and reported how counselors are trained and how various graduate programs implement the CACREP curriculum standard for human development.

Mead et al. (1997) concluded that the training of counselors must be adequate for counselors to report high levels of comfort with their use of the *DSM* as a manual, and with their diagnosis skills. However, Mead et al. did not report on the types of training that the counselors

received and did not ask the respondents to rate their level of identification with various theoretical models.

Hansen (2003) expressed concern over what he perceived as an over-emphasis on *DSM* training in graduate counseling programs. He argued that counselors-in-training, by virtue of the fact that they are new practitioners and lack the experience to have truly internalized the humanistic perspective of counseling, are especially vulnerable to integrating a medically modeled professional identity when working for organizations that perpetuate and encourage medical model policies and practices. Hansen stated that the best way for counselor educators to address this issue is to stress and promote critical thinking in students while at the same time deemphasizing the clinical utility of diagnosis for counselors while strongly emphasizing its clinical utility for psychiatrists. Similarly, Duffy et al. (2002) stated that training programs tend to fail to clearly link the origins of the theories of deriving knowledge (positivist vs. social construction) to present day reconciliations (like Hansen's), presenting a theory of being human that at best is confusing to students trying to figure out the "right" way of practicing counseling (p. 371).

In contrast to Hansen, Ingersoll (2000) advocated for teaching not only diagnosis, but specifically psychopharmacology to counseling students. He disregarded the theoretical conflicts and focused on the practical necessities of diagnosis in his approach to counseling. He argued that harm can befall the client whose counselor is not familiar with the medication that may be prescribed to a client; counselors' effectiveness is diminished when a client is noncompliant with a medication regimen and the counselor is unaware of the possible cause for a change in behavior; and some state laws (e.g., Ohio) require psychiatric medication education (Ingersoll). He outlined a course based on a curriculum created by the American Psychological

Association—demonstrating the lack of consideration this topic in the body of counseling literature, as he had to turn to the APA for a teaching curriculum on this subject (Ingersoll). Ingersoll also made a brief reference to the philosophical conflicts in the counseling field that teaching a medical psychopharmacology course may bring to light; however, he stressed the practical side of the argument, citing his opinion that the need is greater to understand the workings of and the importance of the medicines that clients may be prescribed than whether or not psychopharmacology is an appropriate course for counselors (Ingersoll).

In 1992, Benson, Long, and Sporakowski addressed teaching psychopathology and the *DSM-III-R* within the context of family systems theories. Family systems theories do not include diagnosis. Thus, Benson et al. offered systems-oriented bridges between family systems and diagnosis—including techniques for helping the client family to see the diagnosis systemically. They articulated their belief that the process of assigning diagnostic labels can disengage and devalue clients by not accounting for the systemic profile of the client (Benson et al.). Their recommendations for integrating systemic considerations when diagnosing seemed to be a precursor for Ivey and Ivey's DCT techniques which work with clients within the systems in which they live. Despite difficulties in justifying the use of the *DSM* in family systems therapies, Benson et al. did not dispute that the *DSM* and diagnosis must be taught to counselors.

Eriksen and Kress' (2005) *Beyond the DSM Story: Ethical Quandaries, Challenges, and Best Practices*, is a textbook for counselors-in-training that specifically addresses and intends to reconcile some of the challenges counselors face when making or considering diagnosis of a client. The authors briefly reviewed widely accepted benefits of utilizing the *DSM*, and frame the manual as a necessity in today's counseling practice (Eriksen & Kress). Eriksen and Kress also stated that it is extremely important for counselors to maintain continuous and accurate education

regarding the *DSM*. They posit that counselors who are either poorly trained or resistant to learning the *DSM* system may not only be dangerously incompetent to diagnose, but may be unable to recognize problems in their clients that are beyond the scope of their abilities (Eriksen & Kress).

Eriksen and Kress (2005) attempted to help counselors-in-training rectify the most important problems facing counselors who will practice diagnosis. They did not address in detail the theoretical dilemmas, but instead detailed the cultural and feminist themed conflicts present in the *DSM* and presented case studies relevant to these issues (Eriksen & Kress, 2005).

In 1993, an issue of *Counselor Education and Supervision* contained a special section in an issue regarding teaching the *DSM-III* in counselor education programs. Although dated, the attention given to the topic by a professionally-esteemed journal warrants a discussion in this literature review. Hohenshil (1993), Fong (1993), Cook, Warnke, and Dupuy (1993), and Velásquez, Johnson, and Brown-Cheatham (1993) contributed articles on teaching the *DSM-III*, teaching diagnosis, and gender and cultural concerns when teaching the *DSM-III*. A summary of Fong and Hohenshil's articles is presented in this subsection, while Velásquez et al. and Cook et al. are discussed in the cultural bias and gender bias sections, respectively, of this literature review.

Fong (1993) called for specific instruction in diagnosis in counselor training programs and she outlined how this course could be taught. Drawing from her experience as a psychiatric nurse, Fong articulated her belief that diagnosis is a process in which the helper can conceptualize the client's problems and derive a plan of treatment. She compared the process to solving a large puzzle with the client. She described skill stages in instruction of the course: stage I includes learning how to observe client behavior and conduct a clinical assessment



interview, and stage II includes organizing the behaviors observed into the multiaxial diagnosis specific to the *DSM-III*. Fong stated that diagnosis should be taught to counseling students early in their training. Hohenshil (1993), in agreement with Fong, asserted that a separate course should be taught specifically on the *DSM-III-R*, and that aspects of diagnosis should be integrated throughout the counselor's training—especially before students begin a practicum experience (Hohenshil).

In conclusion, the current and historical literature on the subject of diagnostic training of counselors illuminates the paradoxical opinions on this topic. The debate focuses not so much on whether or not diagnosis must be taught, but on how to teach it and keep a distinct professional counselor identity that does not identify with the traditional medical modeled assumptions of the *DSM*.

### **Culture and Gender Bias, Ethics, and the *DSM***

Despite the reportedly progressive steps in the most recent and future editions, criticisms of the *DSM* continue to appear in the literature regarding its failure to incorporate more multicultural viewpoints in delineating diagnoses (see Ginter & Glauser, 2001; Hinkle, 1999). Scholars have argued that there is both implicit and explicit bias written in and extrapolated from the *DSM* (Ginter & Glauser, 2001; Herlihy & Watson, 2003; Herlihy et al., in press). Despite the efforts and improvements made in the fourth edition text revision to include cultural and/or gender considerations when making a diagnosis (APA, 2000), Ginter and Glauser asserted that the *DSM* fails to encompass a multicultural approach to diagnosis, and instead offers up statistics and relevant, although often stereotypical, information regarding different cultures and the prevalence of the disorders across genders.

## *Cultural Bias*

Absent from the *DSM* is a substantial discussion about how *DSM* diagnosis and cultural competence are reconciled in practice (see Herlihy & Watson, 2003; Kress, Eriksen, Rayle & Ford, 2005). A concern has been expressed that normal gender or culturally appropriate behaviors could be construed as pathology and diagnosed incorrectly, labeling clients with a potentially damaging—and sometimes harshly judged—stigma in some cultures (Herlihy et al., in press). Cultural and gender contextual diagnosis therefore becomes an ethical necessity (Herlihy & Watson; Kress et al.).

Kress et al. (2005) noted that to assume behavior is abnormal, one must assume that there is a standard which applies to all that is considered normal, and they argue that when discussing abnormal behavior, the *DSM* is considered the standard. They further noted that the *DSM* is a body of work created—probably unintentionally—by a group of not very culturally diverse people, and that, therefore, the *DSM* is based on the standard of normal known by the members of that group (Kress et al.). Although defining normal is not a new issue in diagnosis, the issue can serve as a framework for other arguments asserting *DSM* cultural bias. That is, classifying individuals into categories is problematic because not everyone will fit neatly into them.

Neighbors, Trierweiler, Ford and Muroff (2003) found that “Schizophrenia is diagnosed more frequently among African Americans while mood disorders are identified more often among whites” (p. 237). Neighbors et al. conducted diagnostic interviews, utilizing a checklist designed to standardize the *DSM* criteria, with patients at a psychiatric inpatient facility. The relationships between diagnoses and race were analyzed. The most notable relationship was between how clinicians would associate various symptoms to different disorders across races (Neighbors et al.). This phenomenon led the researchers to believe that these results were

attributable in part to clinical judgment and faults lying within the *DSM*, and they encouraged further research into interpretation of client affect by clinicians. Neighbors et al. called for further education and training in both assessment and diagnosis and asserted that "...the preconceived notions clinicians may have about patients based on race, gender, or socioeconomic status, remain an important influence on how patients are assessed" (p. 251). They further concluded that the *DSM* system is deceptive and not as reliable [when diagnosing people of different races] as its authors claim (Neighbors et al.).

The appendix titled "Outline for Cultural Formulation and Glossary of Culture-Bound Syndromes," new in the first edition of the *DSM-IV*, describes 25 patterns of behaviors and beliefs that are deemed by the authors as abnormal or abhorrent in the eyes of Western culture (APA, 2000). This outline has been widely criticized for being a "tourist" collection of the "exotic and unusual" (Smart & Smart, 1997) instead of a comprehensive, thoughtful discussion of culturally bound practices. Smart and Smart further criticized the glossary, noting that it does not contain some diagnoses that are considered to be Western culturally bound, such as anorexia nervosa and chronic fatigue syndrome. These disorders are described in the text of the *DSM* rather than in an appendix, implying these disorders are universal and not culturally bound. According to Smart and Smart, this demonstrates some cultural bias in that the authors of the *DSM* were ethnocentric in their placement of those disorders.

The outline for cultural formation section, however, contains a section reviewing some of the cultural factors that should be explored such as "cultural identity of the individual," "cultural explanations of the individual's illness," "cultural factors related to psychosocial environment and levels of functioning," "cultural elements of the relationship between the individual and the clinician," and "overall cultural assessment for diagnosis and care" (APA, 2000) before

rendering a diagnosis. This section has been acknowledged as a positive, albeit brief discussion of cultural context and diagnosis with the *DSM* (Kress et al., 2005; Smart & Smart, 1997).

Hohenshil (1994) chronicled the changes made for the *DSM-IV* and outlined the major differences both in the format and content of the text. Hohenshil concluded that “The resulting *DSM-IV* is considerably more sensitive to bias issues, more scientific, more logically organized, and better written than any of its four predecessors” (p. 105). Despite Hohenshil’s apparent satisfaction with the changes that were made between the third and fourth editions of the *DSM*, he criticized the manual for using more medical jargon than the previous edition, and for its considerable increase in length (Hohenshil). Seligman (1999) published a retrospective of the state of diagnosis and the *DSM-IV*, echoing Hohenshil’s praise for the revisions made to the fourth edition of the *DSM*. In Seligman’s opinion, the revisions represented a distinct effort to account for the cultural context of the client during the diagnostic process.

Velásquez, Johnson, and Brown-Cheatham (1993) pointed out one quandary not yet raised in this literature review. They asked, do some clients express more pathology in their native language than in English? If so, then the *DSM* could be construed as biased because of its inability to relate to other cultures linguistically. Velásquez et al. also asserted that the documented increase in diagnoses among members of marginalized cultures in American society should be a red flag to contemporary counselors. They addressed these issues and believed that ethical practice could be achieved by helping counselors-in-training understand: (1) the process of *DSM-III-R* diagnosis; (2) the limitations that exist when diagnosing minorities; and (3) various treatment modalities which address the cultural limitations of the *DSM* (Velásquez et al.).

## *Gender Bias*

Some researchers (Cook et al., 1993; Eriksen & Kress, 2005; Herlihy et al., in press) have argued that explicit and implicit gender bias exists in the *DSM*. Eriksen and Kress articulated the feminist belief "...that women's anger, depression, and discontent have been reframed as medical or psychiatric symptoms, and that, as a result, the often difficult and distressing life circumstances of women have been disregarded" (p. 81). Cook et al. asserted that society, as well as individual counselor experiences, affect how pathology is defined, and that gender bias is a natural consequence of the tendency of people to interpret others through their own experiences. They surmised that harmful misdiagnosis can occur if such bias is present.

Eriksen and Kress (2005, 2008) reviewed the literature on feminist theories, criticisms of the *DSM* in regards to the negative views it fosters of women, and how *DSM* nomenclature may bias the perceptions of women clients by practitioners. These authors reviewed historical literature and concluded that men appear to be diagnosed more often with certain disorders (e.g., substance abuse) and women with others (e.g., anxiety disorders). However, this appears not to be the case before school age (2005). They also reported that various published literature supported the idea that women have a propensity to more often be diagnosed due to the assumptions made by the counselor about women (2008). Herlihy et al. (in press) offered several possible reasons why adolescent and adult women are more frequently diagnosed with certain disorders: women's depressive response to a sexist society, biological factors which may predispose them to mood and anxiety disorders, and variations in the ways men and women are socialized to behave.

Eriksen and Kress (2005) identified stereotypic qualities of women that are believed to be "pathologized" in the *DSM*. Cook et al. (1993) noted the prevalence of male-oriented values

associated with ideal “normal” behavior. They asserted that the behaviors most associated with males (e.g., independence, assertiveness) tend to be the socially ideal, mentally healthy behaviors, and mentally unhealthy behaviors are based on the inversion of the healthy ones, which tend to be the behaviors most associated with females (e.g., expressiveness, emotionality). Additionally, Eriksen and Kress (2005, 2008) criticized the inclusion of Premenstrual Dysphoric Disorder (PMDD) in the *DSM*, citing literature by Caplan, McCurdy-Myers, and Gans (1992), who attempted to explain the etiology of this disorder from negative societal perceptions of menstruation and biological, hormonal shifts.

Eriksen and Kress (2005) also cited Brown (1991), who asserted that women are predominantly the victims of trauma such as abuse and domestic violence, and they already may be in a fragile state when they seek treatment. During treatment they are often labeled with a mental illness, which can cause detriments to their self-identity if they internalize the belief that something is wrong with them for falling victim to something they were unable to control (Brown).

Gender bias may exist in the diagnosis of personality disorders due to the clinician’s misappropriation in applying the disorder (Widiger, 2000). Clinicians may base their diagnoses on a small set of criteria which they define on their own as being the most important in delineating a diagnosis and may possibly apply it indiscriminately. Widiger cautioned that due diligence in following the criteria may curb this practice, making the distributions less gender-specific.

In conclusion, Eriksen and Kress (2005) as well as Remer et al. (2001) called for careful consideration and contextual deliberation when diagnosing women, and encouraged the helper to “...co-construct an understanding of the problem with the client, rather than imposing a

diagnosis on the client” (p. 104). Eriksen and Kress endorsed a constructivist approach when counseling women. They urged clinicians to use a contextual assessment of the client to minimize assumptions made about women clients. They suggested further discussion on this topic as they question the application of the *DSM* system to women and culturally diverse populations (Eriksen & Kress). Cook et al. (1993) suggested that comprehensive training, self-awareness of assumptions and experiences in a gender context, and an understanding of the limitations of the *DSM* all help to alleviate the ineffective diagnostic process that can occur if gender bias is not addressed in counseling situations.

### *Ethics and DSM Diagnosis*

Some scholars appear to agree that ethical quandaries inevitably result when a counselor is called upon to diagnose (Eriksen & Kress, 2005; Remley & Herlihy, 2007). The exploration in this subsection of ethics and diagnosis includes: the ethical guidelines published by ACA; information presented by Remley and Herlihy regarding ethical issues involved with diagnosis; and information presented by Braun and Cox (2005) and Glosoff, Garcia, Herlihy, and Remley (1999) in regards to managed care issues.

The *ACA Code of Ethics* (ACA, 2005) is intended as a guide to ethical practice. Section E.5, titled “Diagnosis of Mental Disorders,” contains four subsections intended to address diagnosis in counseling. Subsection E.5.a states, “Counselors take special care to provide proper diagnosis of mental disorders.” The standards address multicultural concerns in both standards E.5.b and E.5.c (p. 11), stating that “Counselors recognize that culture affects the manner in which clients’ problems are defined,” and “Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment.” Also

important to note is subsection E.5.d which allows counselors to not diagnose a client if the counselor "...believes it would cause harm to the client or others" (p.11).

The *ACA Code of Ethics* does not describe specific situations in which diagnosis would be harmful to a client nor does it define "pathologizing" a client. The purpose of the *Code*, however, is to be a *guide* for moral behavior of a practicing counselor, not to specify how each counselor conducts each counseling session (*ACA Code of Ethics*, 2005).

A number of ethical concerns that arise from diagnosing clients have been identified (Remley & Herlihy, 2007). Counselors must attend to issues of informed consent; that is, clients must be able to understand their diagnosis and the personal and professional ramifications of the diagnosis. Clients must be made aware of anyone who will have access to their confidential information, and counselors have a responsibility to discuss with the client the importance and possibility of communication with other health professionals if necessary, and under what circumstances (e.g., the safety of the client and others) disclosure could occur. Remley and Herlihy also considered ethical dilemmas related to client welfare when diagnosing, including a "self-fulfilling prophecy" (p. 261): the manifestation of the characteristics of a disorder in a client because the client internalizes the diagnostic label assigned to him or her.

The ethical ramifications of misdiagnosis and managed care are addressed in the literature (Braun & Cox, 2005; Danzinger & Welfel, 2001; Glossoff et al., 1999; Remley & Herlihy, 2007). Remley and Herlihy suggested that well-intentioned counselors may assign either unnecessary or more severe or less severe diagnoses than warranted. Braun and Cox suggested that clients' misunderstanding or misinformation about: (1) their own insurance benefits; (2) their rights to confidentiality in reference to their insurance company coverage; (3) their right to determine course of treatment with their counselor; (4) their counselor's training in



the treatment techniques endorsed—sometimes required—by their managed care company; (5) their counselor’s requirements in regards to treatment plans; and (6) possible length of treatment, can all contribute to ethical and legal dilemmas when utilizing managed health care in counseling. To avoid these dilemmas, Braun and Cox endorse rigorous training and continuing education for counselors regarding insurance reimbursement and ethical guidelines. They called on counselors to: (1) advocate for insurance reform (2) have thorough discussions with clients about informed consent and their rights and limits to confidentiality; (3) stay abreast of changes in and remain aware of laws concerning managed health care issues; (4) be aware of ethical codes and guidelines; (5) not lie about anything in reference to treating or diagnosing a client (6) and be vigilant about procuring and keeping malpractice insurance (Braun & Cox).

Danzinger and Welfel (2001) conducted an empirical study which sampled 108 counselors to measure their perceptions of managed care companies’ impact on their counseling. They concluded that the participants in their sample identified negative consequences in dealing with managed care companies, including limits to client confidentiality, informed consent, course of counseling treatment, and termination. They also indicated that some of the counselors they surveyed acknowledged engagement in unethical practices in order to seek reimbursement from managed care.

Glosoff et al. (1999) stated that the issue of counselors’ clinical autonomy is raised when managed care companies place limits, in an effort to keep down their costs, on the number of sessions a counselor will be reimbursed with a particular client. Placing a time limit on the number of sessions a client can be seen can severely hamper a counselor’s ability to practice within certain theoretical constructs. Some counselors routinely practice counseling techniques from theoretical constructs which call for an extended number (sometimes years) of sessions in

order to reach all goals set forth by counselor and client. Also, client goals for counseling, regardless of the counselor's theoretical orientation, often require more than a few sessions to reach. Thus, counselors may not think they are allowed to consistently practice the most appropriate or effective counseling techniques with each client. This may serve as an impetus to misdiagnose clients in order to keep them in counseling.

In conclusion, the ethical dilemmas faced by counselors in the process of diagnosis are numerous and cover a wide range of difficulties from the perspective of the client as well as the counselor.

### *Ethics and Diversity*

Herlihy and Watson (2003) stated that: (1) the medical model on which the *DSM* is based infers that mental disorders stem from the individual, and does not account for environmental factors that can proliferate a mental disorder; (2) the system classifies the otherwise normal problems that may occur as a result of being a woman or being of a minority culture as pathology; (3) and the *DSM* is paternalistic—causing the perpetuation of oppression minority clients can feel. They asserted that many of these ethical dilemmas can be confronted and resolved reasonably when the counselor: (1) takes great care to broaden his/her own cultural context and see the client's problems within the client's cultural context; (2) avoids replicating a paternalistic structure within the counseling relationship; (3) and empowers clients to make positive changes within their own social, political, and personal reality construct.

### **Chapter Summary**

This chapter examined the historical and contemporary literature pertaining to the lively debate that currently exists in the counseling field regarding professional counselor training, bias,

and ethical concerns when diagnosing clients, as well as the philosophical contradictions that counselors face when deciding their disposition in regards to diagnosis.

The practice of counseling as opposed to psychology was facilitated by Carl Rogers, who espoused his belief that the relationship between client and counselor superseded the need of the practitioner to classify individuals according to a man-made taxonomy. Criticized by professional peers, Rogers' theories appealed to many counselors-in-training because of their non-judgmental interactions with clients. Thus began the conflict counselors now face when attempting to reconcile their personal counseling theoretical orientation with the practical demands put upon counselors by third-party payors as diagnosticians.

Guidelines for training counselors have evolved to include instruction in the *DSM* classification system as well as knowledge of the human psyche and its propensity for abnormal behavior. Dispute exists about how to properly train counselors to keep counselor identity as Rogers set forth, while still recognizing the importance and expediency of diagnosing and the need for the counseling profession to survive in a crowded field of mental health professions. The professional counseling accrediting body outlines a minimum standard that must be upheld to retain accreditation; however, it is broadly worded, causing further debate about how this training should be accomplished.

The evolving *DSM* was also explored in this review. It is a fluid, changing body of work, and the *DSM-V* contributors now publish discussions that address some of the criticisms of the former editions outlined in this literature review.

Finally, this chapter offered a discussion of the literature surrounding the issue of culture, gender, and ethics when diagnosing. These issues are widely discussed in the professional literature, recounting the various weaknesses of the *DSM-IV-TR* and the disadvantages that

diagnosis can present both for clients and for counselors. Criticizing the *DSM*'s biased nature seems to be a popular topic; however, it remains the most utilized reference when diagnosing clients and is widely accepted throughout the world. Available to counseling professionals is the professional code of ethics when reconciling this topic, as ACA ethical guidelines state the importance and ethical necessity of diagnosing accurately, ethically, and in a culturally appropriate context.

The literature presented in this review demonstrates the need for this study. Mead et al.'s study (1997) is the last comprehensive study of counselors' use of the *DSM*, and it failed to take into account the perspectives of a broad range of professional counselors. The present study included licensed professional counselors in a variety of settings. Literature also suggests a lack of consideration of multicultural and gender issues within the *DSM* (see Remley & Herlihy, 2007; Eriksen & Kress, 2005; Eriksen & Kress, 2008). This study measured counselors' opinions about their ability to practice from a multicultural perspective while diagnosing clients. Finally, literature also suggests several ethical dilemmas (see Braun & Cox, 2005; Danzinger & Welfel, 2001; Remley & Herlihy, 2007, Herlihy & Watson 2003) arise when professional counselors diagnose. This study examined counselors' self-reported experiences with ethical dilemmas regarding diagnosis and the frequency of any such dilemmas; therefore empirically defining these themes for other counselors and counselor educators.

## **CHAPTER THREE**

### **METHODOLOGY**

This chapter presents the methodology used in this study. Subsections include purpose of the study, the general and specific research questions and hypotheses, selection criteria for participants, instrumentation, the expert panel review process, data collection, and methods of data analysis.

#### **Purpose of this Study**

The purpose of this study was to identify LPCs' self-reported perceptions of their preparation, ethical challenges, counseling theoretical orientation, and dispositions regarding bias and use of the *DSM-IV-TR*. This research examined the diagnostic practices of licensed professional counselors, and identified and examined selected factors such as counselors' attitudes toward the adequacy of their training in diagnosis and the *DSM*; perceptions of gender-specific and cultural bias within the *DSM*; and frequency and experience regarding ethical dilemmas as a result of diagnosing clients and utilizing the *DSM*.

The literature is abundant with information on the difficulties faced by counselors when utilizing the *DSM* (Remley & Herlihy, 2007; Eriksen & Kress, 2005), and one study has reviewed the utility of the *DSM-III* (Mead et al., 1997). However, absent from the literature are studies conducted to measure professional counselors' views on the topics of theoretical orientation, ethical challenges, and dispositions regarding the use of the *DSM-IV-TR*. This absence necessitated the need for a study of how these issues are viewed by practicing counselors today.

## General Research Question

The general research question that was addressed in this study is: What are LPCs' perceptions of and attitudes toward their preparation to diagnose and use the *DSM*; their disposition about cultural and gender-specific bias contained within the *DSM*; their encounters with ethical dilemmas in relation to diagnosis and the *DSM*; and the extent to which their theoretical orientation affects their disposition about diagnosis and using the *DSM*?

## Secondary Research Questions

Several specific research questions were derived from the general research question.

These questions were:

1. To what extent do practicing LPCs diagnose clients using the *DSM*?
2. To what extent do LPCs perceive their training was adequate to diagnose and utilize the *DSM* accurately?
  - 2a. How many courses focusing on diagnosis and the *DSM* were taken?
  - 2b. How many post graduate/continuing education hours (CEUs) were taken focusing on diagnosis and the *DSM*?
3. Is there a relationship between the number of courses taken on diagnosis/*DSM* and LPCs' rating of the adequacy of their training?
4. Is there a relationship between how much LPCs identify with the wellness model and their decision to diagnose or not diagnose?
5. Is there a relationship between the perceptions of LPCs who strongly identify with a multicultural perspective and the strength of their agreement with the statement that the *DSM* does not adequately present disorders in such a way as to allow accurate diagnosis of culturally diverse and women clients?

6. What do LPCs identify as the most frequent ethical challenge due to diagnosis and the use of the *DSM*?

### **Research Hypotheses**

The following research hypotheses were derived from both the literature and the general research question. They are:

1. A majority of LPCs surveyed will report that they diagnose clients using the *DSM*.
  - 1a. The most cited reason why they do diagnose will be for billing purposes.
  - 1b. The most cited reason why the participants do not diagnose will be due to legal reasons.
2. LPCs will strongly agree with the statement that their training was adequate to utilize the *DSM* and diagnose accurately.
  - 2a. A majority of LPCs will have had at least one graduate course devoted to *DSM*/diagnosis.
  - 2b. A majority of LPCs will have had at least one continuing education course devoted to the *DSM*/diagnosis.
3. LPCs who completed at least one course in *DSM* instruction and diagnosis will rate the adequacy of their training higher than those who completed fewer courses on that topic.
4. LPCs who indicate that they operate from a wellness perspective will agree that their theoretical orientation plays a large part in their decision to diagnose a client.
5. LPCs who strongly identify with a multicultural perspective will agree that the *DSM* does not adequately present disorders in such a way as to allow accurate diagnosis of culturally diverse and women clients.

6. A majority of LPCs' descriptions regarding the most frequent ethical dilemma they encounter due to diagnosing clients will center on financial issues.

Hypotheses 1, 1a, and 1b were derived from the results of Mead et al.'s (1997) study. Mead et al. reported that over 85% of the time, the CMHCs and other mental health professionals with whom they worked were required "often" or "always" by their job to diagnose clients. The researchers reported that approximately 56% of the CMHCs used the *DSM* to assign the diagnoses. Mead et al. also reported that third-party payment was considered to be the most important factor when considering the use of the *DSM*. It does not appear from the literature that researchers have addressed why counselors may not diagnose clients; however, Mead et al. indicated that 53% of the participants in their study agreed they would diagnose if they were not required to do so. Therefore, it may be that the respondents who did not diagnose may be unable to do so due to training or licensing reasons.

Hypothesis 2 also was derived from Mead et al.'s study which reported CMHCs' mean skill rating in using the *DSM* to diagnose at 7.85 on a scale of 1-10; wherein 1 was the lowest skill level rating and 10 the highest. Hypotheses 2a and 2b were derived from the work of Bradley and Fiorini (1999), Fong (1993), and Seligman (1999). Bradley and Fiorini reported that in 1999, at least 50% of the institutions surveyed required prerequisite coursework in the CACREP curriculum area of human growth and development before students were allowed to begin practicum. Although Bradley and Fiorini did not specifically account for the number of courses, after Fong reported the failure of many programs to incorporate a separate course in teaching diagnosis, Seligman reported an increase in the number of counseling programs incorporating separate courses in the *DSM* and diagnosis. Seligman also reported her perception



that a growing number of continuing education programs (she initiated one herself) about diagnosis was becoming more available to counselors.

Hypothesis 3 was based on the literature by Hohenshil (1993) and Mead et al. (1997). Given Hohenshil's conclusion in 1993 that acceptance was growing of the need for training counselors in diagnosis and the *DSM*, and given Mead et al.'s call for increased training as a way to alleviate the various difficulties of diagnosis, it can be hypothesized that more hours of education will translate into perceptions of greater training adequacy.

Hypothesis 4 was based on the literature by Mead et al. (1997). Mead et al. did not directly question their participants about whether or how their theoretical orientation influenced their decisions to diagnose. They were surprised to report that the CMHCs who saw marriage and family clients and diagnosed those clients overall held an unfavorable view of the *DSM* system in terms of its applicability to marriage and family problems. Mead et al. surmised that insurance reimbursement remained the primary incentive in utilizing the *DSM*.

Hypothesis 5 was based on the requirements of the ACA *Code of Ethics* (2005), and Mead et al. (1997). The *Code* states: "Counselors recognize historical and social prejudices in the misdiagnosis and pathologizing of certain individuals and groups and the role of mental health professionals in perpetuating these prejudices through diagnosis and treatment." (ACA *Code of Ethics* standard E.5.c., 2005) Because ACA requires counselors to practice diagnosis from a multiculturally sensitive position, counselors must embrace the notion that the process of diagnosis and the *DSM* can be biased. Mead et al. reported that one of the more serious disadvantages of the *DSM* was bias and labeling clients.

Hypothesis 6 was derived after reviewing the information contained in Mead et al.'s (1997) study wherein over 70% of the participants reported that they were aware of incidents of

misdiagnosis. This overwhelming number led to the formulation that there is a strong possibility that LPCs will be able to identify ethical dilemmas and their frequency. Danzinger and Welfel (2001) also reported a high frequency of (75%) respondents who indicated that dealing with managed care companies for financial reimbursement presented ethical dilemmas for them.

### **Participants**

Participants in this study were Licensed Professional Counselors (LPCs) or equivalents who hold professional counseling licenses within ACA's Southern region of the United States. To obtain a national list of email addresses from ACA was cost prohibitive and would not exclusively contain LPC addresses. Therefore, the possible participant pool was narrowed down to include the Southern region states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina, Tennessee, Texas, Virginia, and West Virginia. To further generalize the sample, a manual search was conducted to obtain email addresses of LPCs who advertised publicly on the internet as well. Of the approximately 3,000 ACA and online counseling directory members who were contacted, the number of participants in the study was 303.

Personal information regarding the demographics of the participants was gathered in Section I of the *UPDSM*. This information was gathered exclusively for determining differences in opinions and perceptions based on the participants' age, gender, ethnicity, and educational and professional background. Participants were also asked about their related experience with diagnosis, ethical dilemmas, and training.

Data describing the respondents' gender and ethnicity are displayed in Tables 1 and 2.

Table 1

*Frequency Distribution of Respondents by Sex*

Sex	n	%
Female	217	71.61
Male	86	28.10
Totals	303	100

Table 2

*Frequency Distribution of Respondents by Ethnicity*

Ethnicity	n	%
African American	20	6.60
American Indian	1	0.33
Asian American	1	0.33
Caucasian	267	88.12
Hispanic Origin	6	1.98
Pacific Islander	1	0.33
Other	6	1.98
No Response	1	0.33
Totals	303	100

*Note. Responses to "other" included self-described ethnicities: "Caucasian with Hispanic Origin," "Caucasian/American Indian," "Caucasian/Cuban," "Multiracial," and "South Asian."*

The majority of respondents were Caucasian (88.12%) and female (71.62%); the mean age of the respondent was 48 years-old; the mean number of years experience as a counselor was 14; and 1993 was the mean graduation year of the respondents.

Participants were asked to indicate their highest completed level of education as well as which licenses they hold. The frequency distributions for each question are listed in Tables 3 and 4 below.

Table 3

*Frequency Distribution of Respondents by Degree*

Degree	n	%
Doctorate	93	30.69
Master's	210	69.31
Totals	303	100

Table 4

*Frequency Distribution of Respondents by License*

License	n	%
Licensed Professional Counselor	257	84.81
Licensed Marriage and Family Therapist	45	14.85
Licensed Mental Health Counselor	45	14.85
Other	37	12.21

*Note. A list of the responses reported as "other" are contained in Appendix B.*

A majority (69.31%) of the participants indicated their highest level of education completed was a master's degree. Respondents were also asked to indicate all licenses currently held and in which state(s) they are licensed. Therefore, the totals for Table 4 and Table 5 equal more than the number of actual responses. A majority of the respondents (84.81%) indicated they held at least LPC status. Licenses not listed as responses but that were reported by respondents in the *UPDSM* can be found in Appendix B. Respondents were licensed in several states that were outside the surveyed ACA region of this research study. Outside states included Delaware, Idaho, Illinois, Kansas, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, and Washington D.C. Table 5 contains the states and the number and percentage of licenses held in each state by the respondents.

Table 5

*Frequency Distribution of Respondents by State of Licensure*

State	n	%
Alabama	16	5.28
Arkansas	22	7.26
Delaware	1	0.33
Florida	43	14.19
Georgia	31	10.23
Idaho	1	0.33
Illinois	5	1.65
Kansas	1	0.33
Kentucky	20	6.60
Louisiana	34	11.22
Massachusetts	1	0.33
Michigan	2	0.66
Mississippi	23	7.59
New Jersey	2	0.66
New York	1	0.33
North Carolina	4	1.32
Ohio	8	2.64
Oklahoma	1	0.33
Oregon	1	0.33
South Carolina	12	3.96
Tennessee	11	3.63
Texas	47	15.51
Virginia	35	11.55
Washington D.C.	6	1.98
West Virginia	9	2.97

*Note. Participants were asked to list all states in which they were currently licensed. 9.90% of the respondents held licenses in more than one state.*

The data in Table 6 consist of the organizations in which respondents indicated their active membership.

Table 6

*Frequency Distribution of Respondents by Professional Organization*

Organization	n	%
American Counseling Association	281	92.74
State Chapter of American Counseling Association	125	41.25
American Mental Health Counselors Association	49	16.17
Other	155	51.16

*Note. 1.32% of the respondents indicated they were members of no professional organizations. Participants were asked to indicate all memberships; therefore, percentage totals in this table are more than 100%. Responses to “other” are included in Appendix C.*

Respondents were asked to indicate all professional organizations of which they are a member; therefore, the total number of responses to this question was higher than the sample number, and the percentages reported reflect the number of responses out of the total sample of 303. A majority (92.74%) of the respondents were members of ACA. Over 50% of the participants also wrote in other organizations of which they are a member. A detailed list of these self-reported organizations can be found in Appendix C.

Data describing the certification(s) held by the participants are illustrated in Table 7.

Table 7

*Frequency Distribution of Respondents by Certification*

Certification	n	%
National Certified Counselor	167	55.12
Certified Clinical Mental Health Counselor	7	2.31
National Certified School Counselor	13	4.29
Master Addictions Counselor	12	3.96
Not Applicable	88	29.04
Other	73	24.09

*Note. Respondents were asked to indicate all current certifications. Responses to “other” are included in Appendix D. Participants were asked to indicate all certifications; therefore, percentage totals in this table are more than 100%.*

The participants were asked to indicate all of the certifications that they hold; therefore, the total number of responses to this question is higher than the total number of completed surveys, and the percentages are taken from the overall sample of 303. A majority of the respondents (55.12%) indicated they were national certified counselors (NCC), 29.04% indicated this question was not applicable to them, and 24.09% named other certifications they hold—all of which are listed in Appendix D.

Demographic information concerning respondents' practice setting and client age population follows in Tables 8 and 9.

Table 8

*Frequency Distribution of Respondents by Practice Setting*

Practice Setting	n	%
Private for-profit outpatient agency	37	12.21
Non-profit outpatient agency	52	17.16
School (K-12)	33	10.89
Private practice	139	45.87
College counseling center	26	8.58
Inpatient facility/Hospital	21	6.93
University faculty	35	11.55
Other	39	12.87

*Note. 26.07% of respondents practice in more than one setting. Responses to “other” included self-described are listed in Appendix E. Participants were asked to indicate all practice settings; therefore, percentage totals in this table are more than 100%.*

Table 9

*Frequency Distribution of Respondents by Age of Client Population*

Client Age Range	n	%
Children (0-12)	113	37.29
Adolescents (13-19)	211	69.64
Adults (20-50)	243	80.20
Adults (50+)	159	52.48
Not Applicable	9	2.97

*Note. Participants were asked to indicate all client populations they work with. Therefore, percentage totals in this table are more than 100%.*

Respondents were asked to identify all settings in which they practice as well as all age ranges of the clients they service. Therefore the total responses outnumber the sample size of 303. A large number of respondents (139) indicated that they have a private practice and while most respondents worked with clients across the spectrum of age, 80.20% indicated they service adults aged 20-50 years old.

Data describing the distribution frequency of respondents who indicated they graduated from a CACREP-accredited institution are found in Table 10.

Table 10

*Frequency Distribution of Respondents by Graduation from CACREP-Accredited Program*

CACREP Program Trained	n	%
Yes	201	66.34
No	79	26.07
Unsure	23	7.59
Total	303	100

Respondents largely (66.34%) graduated from CACREP-accredited training programs, and 72.28% of the participants indicated that they diagnose clients using the *DSM-IV-TR*.



## Instrument Development

No previous study specifically addressed LPCs' perceptions of diagnosis and uses of the *DSM-IV-TR* in reference specifically to theoretical orientation, cultural and gender-specific bias, and ethical dilemmas. Therefore, existing instruments were not appropriate for this study. Mead et al.'s study (1997) used a quantitative approach in measuring the use of the *DSM-III* by CMHCs, and Mead's survey structure is closely followed in this study in that similar topics such as rating the adequacy of graduate training in diagnosis and the *DSM*, and ethical dilemmas were discussed. Dr. Mead provided me with a copy of her survey, and many of the questions in the *UPDSM* are modeled after hers. Mead et al. (1997) gathered much of the same or similar information sought in my survey, such as whether or not the participants diagnosed clients as a part of their practice, and what the counselors surveyed perceived as the advantages and disadvantages of utilizing the *DSM* and the process of diagnosis. Mead et al. however, did not account for LPCs' experiences with the *DSM* and diagnosis nor did they explore the influences of theoretical orientations on practitioners' disposition toward diagnosis, or whether or not LPCs consider their theoretical orientation when deciding their disposition towards diagnosis. To justify the questions regarding the aforementioned issues not surveyed by Mead et al., literature was reviewed and referenced when formulating the questions contained in the *UPDSM*.

I created the *UPDSM* specifically for this study with the purposes of (a) obtaining clear demographic and educational information about LPCs who diagnose and use the *DSM-IV-TR*, (b) measuring LPCs' perceptions regarding bias and their training, and (c) extrapolating themes regarding LPCs' self-reported experiences with ethical dilemmas centered on diagnosis and using the *DSM-IV-TR*. The *UPDSM* is divided into four sections. The first section contains personal information; the second section includes questions about the participants' experience

and use of the *DSM*; the third section contains statements about training and multicultural issues with which the participants rated their agreement or disagreement; and the last section includes two questions focused on ethical dilemmas LPCs may encounter while practicing diagnosis.

### *Section I: Personal Information*

This section contains 15 questions designed to identify demographic information specific to the participants. Sex; age; counseling experience; ethnicity; degrees, licenses, and certifications earned; organizational memberships; and information regarding graduate school training and curricula are solicited from the participants.

### *Section II: Diagnosis and Use of the DSM-IV-TR*

This section of the *UPDSM* contains four questions designed to identify whether or not participants currently participate in diagnosing clients, the reasons why they do not diagnose if they so answered, their perceptions of the two most important reasons for utilizing diagnosis and the *DSM* if they indicated that they do use it, and how often they diagnose clients. These questions were derived and abbreviated from the questionnaire constructed by Mead et al. (1997), the “Counselors’ Use and Opinions of the *DSM-III-R*”; specifically, questions 20-36 which asked participants to rate the importance of diagnosis from “not important” to “very important” and how frequently they diagnose as “rarely,” “sometimes,” and “often.”

### *Section III: Training, Bias and Theoretical Orientation*

The 26 statements in this section of the questionnaire employed a 7-point Likert scale anchored on a continuum ranging from “strongly disagree” to “strongly agree.” Participants were asked to rate their agreement with the 26 statements to elicit the perceptions of LPCs in regards to their training, bias, professional identity, and theoretical identification.

Questions 2, 3, 6, 7, 8, 9, 11, 12, 14, 15, 16, 18, 19, 23, and 24 all addressed the topic of training. LPCs were asked to rate their perceptions of how their various supervisors and instructors presented the topic of diagnosis to them—perceiving their presentations as “for” or “against” counseling. They were also asked if the topics of diagnosis and the *DSM* were ever discussed in some of their counseling classes. These questions were based on Hansen (2003) who viewed instructors and supervisors as being potentially responsible for student counselors’ perceptions of the medical model and diagnosis. Hansen also suggested de-emphasizing the role of diagnosis in counseling; thus, questions 4 and 21 asked LPCs to rate their agreement with CACREP emphasizing or de-emphasizing diagnostic and *DSM* training in their curriculum standards.

Question 25 was derived from Ingersoll’s (2000) assertion that psychopharmacology should be taught to counseling students; and, therefore, asks the participants to rate their agreement with that assertion.

Questions 1, 5, 13, and 22, in Section III are derived from standards in the *ACA Code of Ethics* that specify counselors’ mandate to practice in a cultural context appropriate to the client (*ACA Code of Ethics*, 2005). Literature regarding counselors’ identification with the wellness perspective (Remley & Herlihy, 2007), and literature about *DSM* training affecting professional identity (Hansen) also influenced the formation of these questions.

Questions 17 and 20 were formulated from the literature about the challenges in diagnosing culturally diverse populations (Smart & Smart, 1997; Eriksen & Kress, 2005).

Question 10 asks participants to rate to what extent they believe their theoretical orientation conflicts with their professional identity as a counselor. This question was derived

from Hansen's (2003) assertion that a strong professional counselor identity includes rejecting any medically modeled theoretical constructs.

Question 26 asked LPCs to rate their agreement with whether or not LPCs should be Medicare providers despite the requirement to diagnose. This question was formulated in response to the advocacy department of ACA which is currently lobbying for such a bill to pass in Congress (ACA website, 2008).

#### *Section IV: Ethical Considerations*

This section of the *UPDSM* consists of two questions designed to elicit both the frequency of LPCs' experiences with ethical dilemmas regarding diagnosis and a brief description of the most frequently occurring dilemma that arises for the participants.

The data used in constructing these statements were extrapolated from Remley and Herlihy (2007) as well as Mead et al. (1997). Mead et al. reported several instances wherein CMHCs cited incidents of ethical dilemmas focusing on misdiagnosis. Remley and Herlihy identified variables such as limits to confidentiality, informed consent, and possible harm to the client as just a few ethically difficult scenarios that LPCs encounter. Question 2 was left open-ended in order to allow respondents to freely express a dilemma in their own terms without being required to share any incriminating information regarding the possibility of misdiagnosis.

Table 11 contains a summary of the references for each question contained in Section III of the *UPDSM*.

Table 11

*Summary of References: Sections II, III & IV of the UPDSM*

Section II Items	Literature Reference
1, 2, 3, 4	Mead et al. (1997)
Section III Items	Literature Reference
2, 3, 4, 6, 7, 8, 9, 11, 12, 14, 15, 16, 18, 19, 21, 23, 24	Hansen (2003)
25	Ingersoll (2000)
1, 5, 13, 22	ACA (2005)
17, 20	Smart & Smart (1997); Eriksen & Kress (2005)
26	ACA (2008)
Section IV Items	Literature Reference
1, 2	Remley & Herlihy (2007); Mead et al. (1997)

**Expert Panel Review**

The *UPDSM* survey was reviewed twice by two different expert panels. All panel members were asked to review the survey items for face and content validity.

The first review was conducted by email, and the members of the panel included five female counselors. Three of the five possessed doctorates in counselor education, all five were LPCs licensed in Louisiana, and another two were qualified LPC supervisors as well. Three of the five panel members were active doctoral candidates. The panel suggested making changes to several questions. The first suggestion included deleting the word “bias” which was used in questions 3-10. The panel thought that this word was too open to interpretation by the reader. An additional suggestion was made by the first round panel to include the selection “university

faculty” in the list of possible practice settings of question 8 in Section I, because it is possible to be a counselor educator and also a practicing counselor. The last suggestion included changing question 3 in Section I to include the phrase “highest education level completed” instead of “highest education level” in order to clarify to the participants how best to answer that question. The suggestions made by the first panel were incorporated into the *UPDSM* and a second expert panel review was convened in person to further evaluate the questionnaire for content and face validity.

Members of the second expert panel were interviewed in a focus group. The panel consisted of four practicing LPCs and one practicing licensed clinical social worker (LCSW), all employed in a private, for-profit agency, but with different therapeutic roles at the agency. All members of the panel attended different graduate school programs in Louisiana and Massachusetts, and the range of experience as licensed counselor practitioners was 3-10 years. Members were diverse in terms of race (one panel member was African-American, the rest Caucasian) and religion.

The panel suggested augmenting question 4 in Section I. The panel indicated that, by including only one space to indicate in which state the respondent is licensed, the survey did not account for those who may hold multiple licenses in different states. Another suggestion in regards to Section I was to clarify item 9 by adding the phrase “master’s level” when asking the participant about the number of courses taken which focused on the *DSM* and diagnosis. The last suggestion made to Section I was to add the choice “unsure” to question 11 to account for those counselors who were not be sure if their program was CACREP accredited.

The panel suggested enhancing question 3 in Section II to include the phrase “...or have past experience in utilizing the *DSM-IV-TR* to diagnose clients...” in order for the question to

allow for an answer from those who have utilized the *DSM-IV-TR* in the past and who may again in the future, to answer this question. The panel's last suggestion was to remove a question that appeared to be a duplicate of its predecessor. The panel's suggestions were integrated into the *UPDSM* survey. The final survey which was mailed to possible participants is found in Appendix A.

### **Data Collection Plan**

All procedures and protocols related to data collection were reviewed and approved by the University of New Orleans Committee for the Protection of Human Subjects Research (IRB), and a copy of the approval letter can be found in Appendix F. After receiving approval, three email lists were compiled. The first list consisted of Southern Region ACA members in Alabama, Florida, Georgia, Louisiana, South Carolina, Tennessee, Texas, and Virginia. The second list consisted of LPC email addresses published on internet-based public directories (<http://www.find-a-therapist.com/>; <http://www.find-a-counselor.net/search.htm>) from the same ACA Southern region states listed above. The third list consisted of ACA Southern Region members in Arkansas, Kentucky, Mississippi, and West Virginia. The details of each mailing list are listed in Table 12.

Table 12

*Participation Mailings and Responses*

List Name	States Surveyed	Sent Messages	Invalid/Opted Out Emails	Incomplete Responses	No License	Completed Responses
ACA Southern Region Mailing List (#1)	AL, FL, GA, LA, SC, TN, TX, VA	1999	698	14	3	210
Manual Internet Search List (#2)	AL, FL, GA, LA, SC, TN, TX, VA	91	11	5	0	23
ACA Southern Region Mailing List (#3)	AK, KY, MS, WV	869	47	8	8	70
Totals		2959	756	27	11	303

As mentioned in the Participants subsection, due to the cost of obtaining a national email address list from ACA, the sample for this study was drawn both from states identified as part of the Southern region of ACA and from a manual internet search of counselors in the same Southern region. States surveyed were Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, South Carolina, Tennessee, Texas, Virginia, and West Virginia. Criteria for participation included licensed professional counselor status, a working email address, the ability to use and complete the survey on the internet, and membership in ACA or one of the public directories of counselors accessible via the internet.

Data were collected anonymously using Survey Monkey (<http://www.surveymonkey.com>), an online survey and data collection service. The *UPDSM* survey was developed for use as an online survey using the program provided by Survey Monkey. Access to the survey was created through a secure link that was provided in the electronic mailing requesting participation in the study.



A total of nine email messages were sent to three sets of potential participant email address lists. Of the 2,959 messages sent, 756 were returned as invalid or the recipient opted-out of the mailing list through a link provided by Survey Monkey. The potential participant pool was then reduced by the number of those returned mailings to 2,203. A total of 27 recipients began the survey and did not complete it, and 11 responses were eliminated because the respondent indicated that he/she held no professional counseling license. The first mailing list yielded 210 completed responses; the second list yielded 23; and the third mailing list yielded 70 responses. A total of 303 completed and valid surveys were returned, generating a response rate of 13.75%. Several potential participants gave reasons for not completing the *UPDSM*. These reasons ranged from not being licensed, to not having the time to complete the study. Other reasons given to the researcher by potential participants who did not answer the survey were: (1) too busy with their practice/job to complete the survey (2) retired or not practicing (3) did not feel invested enough in researching this topic and did not want to answer. It was also noted by the researcher that a large number of potential participants employ spam blockers when receiving their email; therefore, many may have never received the invitation to participate.

The participants were contacted via mass email messages. The letters sent to the participants included an abbreviated description of the study, assurances regarding anonymity, and the method of electronic consent to participate in the study. The mailings contained instructions and a secure access link to the survey from the email message. No other identifying information was gathered by the researcher. Therefore, participation was voluntary and anonymous.

According to the data in Table 12, a large number of emails (698) were returned as undeliverable after the first mailing of the first ACA Southern Region Mailing List #1; therefore

the second (Manual Internet Search List #2) and third (ACA Southern Region Mailing List #3) lists were compiled to ensure an acceptable response rate. Subsequent second and third emails asking for participation in the research study were sent to all three lists—each message going out approximately two weeks after the previous one.

One final, fourth email was sent to the participants at the conclusion of this research study to thank the participants, inform them of the conclusion of the study, and explain how they may request the final results of the study. All four messages to both the potential and actual participants are contained in Appendix F.

### **Data Analysis**

Hypothesis #1: A majority of LPCs surveyed will report that they diagnose clients using the *DSM-IV-TR*.

1a. The most important reason why LPCs diagnose clients will be due to billing purposes.

2a. The most cited reason why the participants do not diagnose clients will be due to legal reasons.

Data Analysis: Data for these hypotheses was gathered from questions 1, 2, and 3 in Section II of the *UPDSM*. This data was analyzed and presented utilizing descriptive statistical measures of central tendency.

Hypothesis #2: LPCs will strongly agree with the statements that their training was adequate to utilize the *DSM* and diagnose accurately.

2a. A majority of LPCs will have had at least one graduate course devoted to *DSM*/diagnosis.

2b. A majority of LPCs will have had at least one continuing

education course devoted to the *DSM*/diagnosis.

Data Analysis: Data for these hypotheses were gathered from questions 2 and 6 of Section III of the *UPDSM* as well as questions 10 and 11 in Section I of the *UPDSM*. Measures of central tendency and chi squared tests were utilized to determine the percentages of LPCs who indicate that their training was or was not adequate.

Hypothesis #3: LPCs who completed at least one course in *DSM* instruction and diagnosis will rate the adequacy of their training higher than those who completed fewer courses on that topic.

Data Analysis: Data for this hypothesis was gathered from questions 2 and 6 in Section III of the *UPDSM* as well as questions 10 and 11 from Section I. A Pearson Product moment correlation was used to compare the perceptions of adequacy by LPCs who had at least one course in *DSM* instruction and the perceptions of adequacy by LPCs who did not have any or less than one course in instruction and use of the *DSM*.

Hypothesis #4: LPCs' scores indicating their strong identification with the wellness perspective will be positively correlated to scores signaling that theoretical orientation plays a large part in LPCs' decision to diagnose a client.

Data Analysis: Data for hypothesis 4 was gathered from questions 10 and 22 in Section III of the *UPDSM*. A Pearson product moment correlation was used to correlate perceived levels of influence from their theoretical perspective on their decision to diagnose.

Hypothesis #5: LPCs' scores indicating their identification with a multicultural perspective will be positively related to the scores indicating LPCs' belief that the *DSM* does not adequately present disorders in such a way as to allow accurate diagnosis of culturally diverse and female clients.

Data Analysis: Data for hypothesis 5 was gathered from questions 1, 13, and 17, and 20 of Section III of the *UPDSM*. A Pearson product moment correlation was used to correlate LPCs' identification with multicultural ideas and their beliefs regarding bias in the *DSM*.

Hypothesis #6: A majority of LPCs' descriptions regarding the most frequent ethical dilemma they encounter due to diagnosing clients will center on financial issues.

Data Analysis: Data for hypothesis 6 was gathered from questions 1 and 2 in Section IV of the *UPDSM*. Measures of central tendency were used to describe the frequency of self-reported ethical dilemmas, while the phenomenological question 2 was read and analyzed for any recurring themes.

#### *Post hoc Reliability Analyses*

The content validity and internal reliability of the survey instrument were calculated on post survey response data using Cronbach's alpha statistic.

## **CHAPTER FOUR**

### **RESULTS**

This chapter contains the results from the analysis of the data as well as a summary of results. First, the research question is stated. The data are then organized by a descriptive statistical analysis of Section III of the *UPDSM*. Following that, each hypothesis test is described and results are reported.

#### **Research Question**

The general research question addressed in this study was: What are LPCs' perceptions of and attitudes toward their preparation to diagnose and use the *DSM*; their disposition about cultural and gender-specific bias contained within the *DSM*; their encounters with ethical dilemmas in relation to diagnosis and the *DSM*; and the extent to which their theoretical orientation affects their disposition about diagnosis and using the *DSM*?

#### **Descriptive Statistics**

The "LPC Uses and Perceptions of the *DSM-IV-TR*" (*UPDSM*) instrument contained four sections. Section I included participant demographic information which was detailed in Chapter 3. Section II included questions about participants' coursework, employment, whether or not they currently diagnose clients and their reasons why or why not. Section III consisted of a series of statements with which participants were asked to rate their agreement on a 7-point Likert scale with 7 indicating strong agreement with the statement and 1 indicated strong disagreement with the statement. The statements addressed cultural issues, training, and theoretical orientation and diagnosis. Section III was completed by the 219 participants (of 303) who indicated that they do diagnose using the *DSM*. Sample sizes, means, and standard deviations for the 26 statements contained in Section III of the *UPDSM* are detailed in Table 13.

To highlight which statements participants most agreed with and the statements participants most disagreed with, the statements in Table 13 are presented in declining order according to their mean.

Table 13

*Means and Standard Deviations of Items 1-26 in Section III of the UPDSM*

Item	<i>n</i>	<i>M</i>	<i>SD</i>
I am a multiculturally competent practitioner	219	5.50	1.27
My licensing supervisor appeared to be in favor of diagnosis and using the <i>DSM</i> .	219	5.12	1.71
The university graduate courses I completed adequately taught me the organization and structure of the <i>DSM</i> so I may understand and use it in practice.	219	5.03	1.73
The practicum/internship supervision I received from my university during my university graduate program appeared to be in favor of diagnosis and using the <i>DSM</i> .	219	4.98	1.67
CACREP standards should increase emphasis on <i>DSM</i> and diagnostic training within counselor education programs.	219	4.96	1.65
My university instructors appeared to be in favor of diagnosis and using the <i>DSM</i> in my training program.	219	4.90	1.64
The university graduate courses I completed adequately prepared me to recognize <i>DSM</i> mental disorders and diagnose them accurately.	219	4.78	1.67
Courses I completed in diagnosis and the <i>DSM</i> included a discussion about multicultural issues when diagnosing clients.	219	4.61	1.81
Courses I completed in multiculturalism included discussion about diagnosis and the <i>DSM</i> .	219	4.37	1.89

Table 13, continued

*Means and Standard Deviations of Items 1-26 in Section III of the UPDSM*

Item	<i>n</i>	<i>M</i>	<i>SD</i>
I believe the <i>DSM</i> does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse clients accurately.	219	4.36	1.73
I believe the <i>DSM</i> does not adequately present disorders in such as way as to allow LPCs to diagnose women accurately.	219	4.32	1.84
Courses I completed in diagnosis and the <i>DSM</i> included a discussion about using the <i>DSM</i> while still practicing counseling theories that emphasize non-judgmental approaches with clients.	219	4.26	1.99
When diagnosing clients, I practice from a wellness oriented/developmental perspective.	219	4.20	2.02
I think counseling accreditation standards should require training in psychopharmacology.	219	4.19	2.40
When diagnosing clients, I practice from a multicultural perspective.	219	4.16	2.08
My licensing supervisor appeared to be against diagnosis and using the <i>DSM</i> .	219	4.14	2.35
Counselor education programs should increase the amount of required instruction on diagnosis and the <i>DSM</i> .	219	4.14	2.00
I believe LPCs should be Medicare and Medicaid providers despite requirements to provide client diagnoses.	219	4.05	2.53



Table 13, continued

*Means and Standard Deviations of Items 1-26 in Section III of the UPDSM*

Item	<i>n</i>	<i>M</i>	<i>SD</i>
The on-site supervision I received during my university practicum/internship graduate program appeared to be against diagnosis and using the <i>DSM</i> .	219	4.05	2.27
The practicum/internship supervision I received from my university supervisor during my university graduate program appeared to be against diagnosis and using the <i>DSM</i> .	219	3.95	2.29
CACREP standards should de-emphasize <i>DSM</i> and diagnostic training within counselor education programs.	219	3.90	2.14
My university instructors appeared to be against diagnosis and using the <i>DSM</i> in my training program.	219	3.89	2.26
Courses I completed in counseling theories did not include discussion regarding diagnosis and the <i>DSM</i> .	219	3.89	2.17
The on-site supervision I received during my university practicum/internship graduate program appeared to be in favor of diagnosis and using the <i>DSM</i> .	219	3.89	2.01
I attribute my decision to diagnose or not diagnose clients to my theoretical orientation.	219	3.69	1.99
Using the <i>DSM</i> in practice conflicts with my professional identity as a counselor.	219	2.70	1.87

*Note.* Participants were asked to rate the above items on a scale from 1-7. An answer of 1 indicated they strongly disagreed with the statement, 7 indicated their strong agreement, and 4 indicated they were unsure.

The means and standard deviations contained in Table 13 illustrate the wide range of responses, with participants generally indicating agreement with some items and generally indicating disagreement with other items. Participants overall agreed most strongly with the statements, “I am a multiculturally competent counselor” ( $M=5.50$ ), “The university graduate courses I completed adequately taught me the organization and structure of the *DSM* so I may understand and use it in practice,” ( $M=5.03$ ) and “My licensing supervisor appeared to be in favor of diagnosis and using the *DSM*” ( $M=5.12$ ). Participants disagreed overall most strongly with the statements, “Using the *DSM* in practice conflicts with my professional identity as a counselor” ( $M=2.70$ ,  $SD=1.87$ ), and “I attribute my decision to diagnose or not diagnose clients to my theoretical orientation” ( $M=3.69$ ,  $SD=1.99$ ).

Large standard deviations (2.00 and greater) for 12 of the 26 items indicated a wide range of responses to the items. On item 26, which read, “I believe LPCs should be Medicare and Medicaid providers despite requirements to provide client diagnoses” ( $SD=2.53$ ,  $M=4.05$ ), the responses were almost evenly split between those who agreed with this statement and those who disagreed with this statement. Item 25 read, “I think counseling accreditation standards should require training in psychopharmacology.” This statement also produced a similar result ( $M=4.19$ ,  $SD=2.40$ ).

These descriptive statistics illustrate both a narrow range of perceptions indicating agreement regarding multicultural competency and professional identity, and a wide range of perception indicating lack of agreement regarding training requirements and professional parity. To further examine these results, the six hypotheses detailed in the methodology chapter of this study were tested, and the results of the data analyses follow.

## Tests of Hypotheses

The “LPC Uses and Perceptions of the *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision*” (*UPDSM*; see Appendix A) was created to answer the above research question by building on a study conducted by Mead et al. (1997). Details of each hypothesis test and the results are discussed in this subsection.

### *Test of Hypothesis 1*

Research hypothesis 1 stated that a majority of LPCs diagnose clients using the *DSM-IV-TR*; that those LPCs will cite billing-related reasons as the most important reason they diagnose; and that those LPCs who do not currently diagnose will cite legal reasons as their most common reason why not.

Responses to questions 1, 2, and 3 in Section II of the *UPDSM* were analyzed in order to test all three portions of this hypothesis. The frequency distribution indicating a majority (72.28%) of the respondents do diagnose clients using the *DSM-IV-TR* is listed in Table 14. Therefore, the data analysis supported this first portion of research hypothesis 1.

Table 14

### *Frequency Distribution of Respondents by Diagnostic Practice*

Diagnose Clients with <i>DSM-IV-TR</i>	n	%
Yes	219	72.28
No	84	27.72
Total	303	100

Those LPCs who indicated that they diagnose clients (n=219) cited the most important reason for diagnosing clients was to receive insurance reimbursement (n=82, 37.44%), and those LPCs who do not diagnose (n=84) cited their most common reason why was because it was not a

requirement for their job (n=72, 85.71%). The data used to test this hypothesis are detailed in Tables 15 and 16.

Table 15

*First and Second Self-reported Most Important Reasons for Diagnosing Clients*

Reasons	Most Important		Second Most Important	
	n	%	n	%
It is a necessary tool for the continuity of care with other mental health professionals for the clients I service.	36	16.44	55	25.11
It is a tool useful for practitioners to identify and treat mental health problems.	66	30.14	51	23.29
Diagnosis is necessary for insurance reimbursement	82	37.44	49	22.37
It helps to dictate a plan of treatment for clients	31	14.15	51	23.29
Other Reasons	4	1.83	13	5.94

Table 16

*Frequency Distribution of LPCs' Self-reported Reasons for Not Diagnosing Clients*

Reasons	n	%
My job does not include/require diagnosing clients	72	85.71
I do not believe that diagnosis is an appropriate practice in counseling	16	19.04
Other Reasons	16	19.05
My training did not adequately prepare me to utilize the <i>DSM</i>	10	11.90
It is unlawful in my state for LPCs to diagnose clients	5	5.95

*Note. Participants were asked to indicate all reasons for not diagnosing clients. Therefore the n is larger than the sample of n=84.*

Sixteen people responded that they do not diagnose for reasons other than what were already listed in the question as described in Table 15. Three themes were prevalent. Five respondents indicated they do not diagnose because they do not accept insurance, one respondent indicated that he/she graduated before diagnosis and the *DSM* was regularly used by counselors, six respondents indicated they do not diagnose as they do not like to “label” or “stereotype” others and it went against their theoretical beliefs as counselors, and two said they work in counseling specialties (e.g., career counseling) that they believed do not require diagnosis of clients. The remaining two written responses indicated that they do use the *DSM* on occasion, but only as a resource and not as a diagnostic tool.

The second portion of this research hypothesis stated that the most cited reason LPCs would give for diagnosing clients would be related to billing issues. Therefore, this portion of the hypothesis was supported by the data. However, the third portion of the research hypothesis was not supported, because participants indicated legal reasons (n=5, 5.95%) as the least cited reason for not diagnosing clients and not the most cited reason.

### *Test of Hypothesis 2*

Research hypothesis 2 stated that LPCs will significantly agree with the statements that their training was adequate to utilize the *DSM*, and that their training was adequate to diagnose accurately; that a majority of LPCs will have had at least one graduate course devoted to *DSM*/diagnosis; and that a majority of LPCs will have had at least one continuing education hour devoted to *DSM*/diagnosis.

Responses to items 2 and 6 from Section III of the *UPDSM* were used to measure the participants' perceived adequacy of their training in diagnosis and utilization of the *DSM*. Participants who indicated they currently diagnose clients using the *DSM* (n=219) were asked to respond to these two items by rating from 1-7 the strength of their agreement with them (1 being strongly disagree, 7 being strongly agree, and 4 being unsure). Participants' responses were separated into two categories—those who answered 1, 2, or 3 and those who answered a 5, 6, or 7. The number of respondents in each category, their means, and standard deviations for each category and each item are listed in Table 17.

Table 17

*Means and Standard Deviations for Items 2 and 6 in Section III of UPDSM by Agreement*

Item	n	M	SD
<i>Agreed with item</i>			
The university graduate courses I completed adequately taught me the organization and structure of the <i>DSM</i> so I may understand and use it in practice.	155	5.99	.773
The university graduate courses I completed adequately prepared me to recognize <i>DSM</i> mental disorders and diagnose them accurately.	145	5.81	.736
<i>Disagreed with item</i>			
The university graduate courses I completed adequately taught me the organization and structure of the <i>DSM</i> so I may understand and use it in practice.	44	2.14	.824
The university graduate courses I completed adequately prepared me to recognize <i>DSM</i> mental disorders and diagnose them accurately.	54	2.28	.712

A slightly greater number of participants agreed with the two statements rather than disagreed (n=155 for item 2, n=145 item 6). However, in order to determine if these numbers were significant enough to support the research hypothesis, a chi square test was done.

The first chi square test was computed for those who agreed with item 2. After computing the chi squared test statistic ( $\chi^2(2) = 3.768, p > .01$ ) it was determined that responses given could have been due to random chance and thus, were not significantly different from each other. The second chi square test was computed for those who agreed with item 6. After computing the chi square test statistic, ( $\chi^2(2) = 13.338, p < .01$ ) it was determined that these responses were not due

to chance. Therefore, it was determined that the respondents significantly agreed with the statement that the university graduate courses participants completed adequately prepared them to recognize *DSM* mental disorders and diagnose them accurately.

The first portion of research hypothesis 2 stated that participants would significantly agree with statements indicating they were adequately trained to utilize the *DSM* and diagnose clients. The data analysis done in this instance was unable to support both portions of the research hypothesis because the respondents only significantly agreed with one statement. The data supported the hypothesis that LPCs perceived that their training in diagnosis was adequate, however, the data did not support the hypothesis that LPCs perceived their training in using the *DSM* was adequate.

The second portion of research hypothesis 2 stated that a majority of LPCs will have completed at least one graduate course and one continuing education hour focused on the *DSM*/diagnosis. Items 10 and 11 in Section I of the *UPDSM* asked the participants to list the number of courses and the number of continuing education hours, respectively, that they completed which focused on *DSM*/diagnosis. A majority of the 303 participants, n=277 (91.41%), indicated they completed at least one course, and a majority n=248 (81.85%), indicated they completed at least one hour of continuing education. The mean number of graduate courses taken by all 303 participants was 2.35, and the mean number of completed continuing education hours was 23.56. Based on the data analyses, this portion of the research hypothesis was supported, and a majority of LPCs reported taking at least one or more graduate course and at least one or more continuing education credit focused on diagnosis/*DSM*.



### *Test of Hypothesis 3*

Research hypothesis 3 stated that LPCs who completed at least one course in *DSM* instruction and diagnosis will rate the adequacy of their training higher than those who completed fewer courses on that topic. Data for this hypothesis were gathered from questions 2 and 6 in Section III of the *UPDSM* as well as question 10 from Section I. A point biserial correlation was used to compare the perceptions of adequacy by LPCs who had at least one course in *DSM* instruction, and the perceptions of adequacy by LPCs who did not have any or less than one course in instruction and use of the *DSM*.

Eleven (3.63%) of the 303 respondents answered that they both currently diagnose clients and completed zero courses focused on *DSM*/diagnosis. Two hundred eight (68.65%) of the 303 respondents answered that they both currently diagnose clients and completed at least one course focused on *DSM*/diagnosis. The first point biserial correlation was conducted to determine if LPCs would rate the adequacy of their training in the organization and structure of the *DSM* (item 2) higher with more coursework. A significant positive correlation was found ( $r(219) = .269, p < .01, r^2 = .072$ ). The effect size (.072) in this instance was small, indicating that 7.2% of the variance was shared by the two variables. The second point biserial correlation was conducted to determine if LPCs would rate the adequacy of their training in the process of diagnosis higher with more coursework. A significant positive correlation was found when comparing the coursework taken with item 6 ( $r(219) = .257, p < .01, r^2 = .066$ ). The effect size (.066) in this instance was small, indicating that 6.6% of the variance between the two items was shared. The means and standard deviations for Items 2 and 6 in Section III of the *UPDSM* are separated by the amount of coursework taken, and are detailed in Table 18.

Significant positive correlations were found between the number of courses taken focusing on diagnosis and the *DSM* and the participants' perception of the adequacy of their training. The data analysis therefore supported research hypothesis 3.

Table 18

*Means and Standard Deviations for Items 2 and 6 in Section III of UPDSM by Coursework Completed*

Item	<i>n</i>	<i>M</i>	<i>SD</i>
<i>Less than 1 hour of coursework in DSM</i>			
The university graduate courses I completed adequately taught me the organization and structure of the <i>DSM</i> so I may understand and use it in practice.	11	3.00	2.28
The university graduate courses I completed adequately prepared me to recognize <i>DSM</i> mental disorders and diagnose them accurately.	11	2.91	2.07
<i>More than 1 hour of coursework in DSM</i>			
The university graduate courses I completed adequately taught me the organization and structure of the <i>DSM</i> so I may understand and use it in practice.	208	5.13	1.64
The university graduate courses I completed adequately prepared me to recognize <i>DSM</i> mental disorders and diagnose them accurately.	208	4.88	1.60

*Test of Hypothesis 4*

Research hypothesis 4 stated that LPCs' scores indicating their identification with the wellness perspective would be positively correlated to scores indicating that their theoretical orientation plays a large part in LPCs' decision to diagnose a client.

Data for hypothesis 4 were gathered from questions 10 and 22 in Section III of the *UPDSM*. The respondents' scores indicating agreement with item 22 (ranking their agreement with a 5, 6, or 7) were compared to their scores on item 10. A Pearson product moment correlation was used to correlate perceived levels of influence from their theoretical perspective on their decision to diagnose. No significant correlation was found ( $r(219) = .149, r^2 = .022, p = .069$ ), and the research hypothesis was not supported. The means and standard deviations for these two items are listed in Table 19.

Table 19

*Means and Standard Deviations for Items 10 and 22 in Section III of the UPDSM*

Item	<i>n</i>	<i>M</i>	<i>SD</i>
I attribute my decision to diagnose or not diagnose clients to my theoretical orientation.	219	3.69	1.99
When diagnosing clients, I practice from a wellness oriented/developmental perspective.	219	4.20	2.02

*Test of Hypothesis 5*

Research Hypothesis 5 stated that LPCs' scores indicating their self-reported identification as multiculturally competent counselors and their self-reported use of a multicultural perspective when diagnosing clients, would be positively related to their scores

indicating belief that the *DSM* does not adequately present disorders in such a way as to allow accurate diagnosis of culturally diverse and female clients.

Data for hypothesis 5 were gathered from items 1, 13, 17, and 20 in Section III of the *UPDSM*. These items asked the participants to indicate their agreement with statements about their perceptions of their multicultural competency and utilization of multicultural perspectives in practice; and about their perceptions of how the *DSM* presents disorders in regards to both women and culturally diverse populations. The participants were asked to respond to these two items by rating the strength of their agreement from 1 (strongly disagree) to 7 (strongly agree) with a rating of 4 being unsure. Four Pearson product moment correlations were used to determine if those LPCs who indicated they were multiculturally competent or indicated that they utilize a multicultural perspective when diagnosing clients also indicated they believed the *DSM* does not present disorders in such a way as to allow LPCs to diagnose both culturally diverse populations and women accurately. Therefore, only those who scored a 5, 6, or 7 on items 1 or 13 had those scores compared to their scores on items 17 and 20.

The first correlation performed compared item 1 with item 17, and no significant correlation was found ( $r(183) = -.043, r^2 = .002, p = .281$ ). The second correlation performed compared item 1 with item 20, and no significant correlation was found ( $r(183) = .005, r^2 = .000, p = .472$ ). The third and fourth correlation performed compared item 13 with items 17 and 20 respectively. No significant correlations were found ( $r(104) = .154, r^2 = .024, p = .059$ ), ( $r(104) = .067, r^2 = .004, p = .250$ ). Therefore, the results of the data analyses did not support research hypothesis 5. Listed in Table 19 are the means and standard deviations for the above referenced items.

Table 20

*Means and Standard Deviations for Items 1, 13, 17, and 20 in Section III of the UPDSM*

Item	<i>n</i>	<i>M</i>	<i>SD</i>
I am a multiculturally competent practitioner.	219	5.50	1.27
When diagnosing clients, I practice from a multicultural perspective.	219	4.16	2.08
I believe the <i>DSM</i> does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse clients accurately.	219	4.36	1.73
I believe the <i>DSM</i> does not adequately present disorders in such a way as to allow LPCs to diagnose women accurately.	219	4.32	1.84

*Note. The means and standard deviations in this table include all currently diagnosing participants.*

*Test of Hypothesis 6*

Research hypothesis 6 stated that LPCs' descriptions regarding the most frequent ethical dilemma they encounter due to diagnosing clients will center on financial issues. Of the 219 respondents who reported that they currently diagnose clients, 140 chose to answer question 2 in Section IV of the *UPDSM*, which asked the participants to describe, in their own words, their most frequently occurring ethical dilemma related to diagnosis or the *DSM*.

Item 2 in Section IV of the *UPDSM* was analyzed by utilizing a grounded theory approach and open coding techniques (see Cohen, Manion, and Morrison, 2007). Data were specifically analyzed by: 1) reading and re-reading the participants' open-ended responses, 2) coding the data according to the emerging themes, 3) re-reading the responses to organize sub-themes within the data until reaching saturation, and 4) counting the frequency of those themes.

Eight major issue-based themes were identified in the data. These themes were: 1) Financial Issues—66 respondents (47.14%) of the 140 responses to this question discussed issues centered on diagnosing in order to get paid for services. 2) Labeling issues—42 respondents (30.00%) indicated that labeling issues were an ethical dilemma. Sub-categories emerged in relation to how a diagnostic label may affect a client's: future ability to retain services or employment; ability to avoid stigmas that surround the label; ability to have a client/counselor untainted by a diagnostic label. 3) Population-specific issues—26 respondents (18.57%) identified these issues specific to client population. Sub-categories identified focused on children and adolescents, and clients with multicultural origins as well as issues specific to marriage and family clients. Concerns included how children and adolescents are diagnosed at too young of an age, and how being of a diverse origin may bring about issues perceived by the therapist as pathological instead of culturally appropriate. 4) Theoretical/Belief System of counseling issues—7 (5%) respondents indicated that diagnosis was either not useful or the therapist believed it harmful to the client and therefore avoided by the respondents. 5) Legal issues—6 (4.29%) responses discussed legal issues. Sub-categories emergent from these answers were divorcing couples and other issues pertinent to the court system. 6) Professional diagnostic issues—with 5 (3.57%) descriptions were separated into two sub-categories. Those sub-categories included working with other diagnosticians and misdiagnosis. 7) Training issues—3

(2.14%) respondents discussed dilemmas about diagnosis of pervasive developmental disorders.

8) Practice setting issues—3 (2.14%) respondents indicated that their primary reason for not practicing in certain settings was specifically to avoid having to diagnose for any other reason than the respondents feeling it was appropriate to do so. Sub-categories were identified by the responses focused on a K-12 school, a university, and a public agency.

Analysis of the data in this instance supported research hypothesis 6 because a majority of the respondents discussed financial issues as the most frequently occurring ethical dilemma they face when diagnosing clients. The themes described above are listed along with supporting quotes from the respondents are listed in Table 21.



Table 21

*Themes from responses to item 2 in Section IV of the UPDSM*

Themes	<i>n</i>	Supporting Quotes
Financial Issues Adjusting Diagnosis(es) to obtain insurance reimbursement	66	<ul style="list-style-type: none"> <li>• “...the temptation is to use a more severe diagnosis than is strictly appropriate so that the client may qualify for a greater level of care than the less severe diagnosis.”</li> <li>• “Being forced to diagnose a client for insurance reimbursement...”</li> <li>• “...I frequently use Adjustment D/O as an initial diagnosis and wait to see how they respond before changing the diagnosis to something considered more serious. Insurance does not reimburse for V-codes which is unfortunate.”</li> <li>• “SIB [self-injurious behavior] clients are not covered for hospital stays unless they are diagnosed as suicidal.”</li> </ul>

Table 21, continued

*Themes from responses to item 2 in Section IV of the UPDSM*

Themes	<i>n</i>	Supporting Quotes
Labeling Issues Refusal of Services Stigma Counselor/Client Relationship	42	<ul style="list-style-type: none"> <li>• “To place labels on young adult and adolescent clients that stay with them throughout life and may give them some degree of hopelessness.”</li> <li>• “...diagnosis may stereotype the individual and reduce the expectation of their ability to change from the perspective of their providers.”</li> <li>• “Diagnosis might prevent employment.”</li> <li>• “...the dilemma is that the threat of an unfavorable ‘label’ interferes with the client’s willingness to disclose symptoms and with that client’s sense of safety with his/her therapist...”</li> <li>• “I am afraid that [an] Axis II [diagnosis] on a permanent record could harm them rather than help them...”</li> <li>• “With diagnosis, the most common ‘pull’ is the desire not to have to make a diagnosis that will go into an individual’s insurance and health care record and follow them.”</li> </ul>

Table 21, continued

*Themes from responses to item 2 in Section IV of the UPDSM*

Themes	<i>n</i>	Supporting Quotes
Population Specific Issues	26	<ul style="list-style-type: none"> <li>• “I usually choose not to use <i>DSM</i> dx [diagnosis] for clients with culturally biased experiences or values that would explain <i>DSM</i> disorders.”</li> <li>• “Issues around diagnosis of substance abuse or substance dependency as it applies to children and adolescents. Current <i>DSM</i> does not allow for developmental issues often faced with this group of clients.”</li> <li>• “Are symptoms that the child is presenting with indicative of a <i>DSM</i> diagnosis or the result of the environment in which the child is currently residing?”</li> <li>• “When a family presents with systemic problems that cannot be explained by the diagnosis of only one individual.”</li> </ul>
Multicultural Minors Family vs. Individual Clients		
Theoretical/Belief System of Counseling	7	<ul style="list-style-type: none"> <li>• “Having a reasonable belief that diagnosis may cause harm to the client.”</li> <li>• “My primary purpose is to assist the client with the issues at hand. Diagnosis is too medicalized to serve this purpose.”</li> </ul>

Table 21, continued

*Themes from responses to item 2 in Section IV of the UPDSM*

Themes	<i>n</i>	Supporting Quotes
Legal Issues Courts Divorce	6	<ul style="list-style-type: none"> <li>• “Working with clients and their lawyers or spouse’s lawyers.”</li> <li>• “Making a diagnosis of a good parent that will be used against them in court.”</li> <li>• “Axis II diagnosis relating to individual in the criminal justice system. There is some stigma to ‘Antisocial Personality Disorder’ that distracts from our primary purpose of helping individuals – probation officers sometimes see that diagnosis and it decreases their efforts in helping clients.”</li> </ul>
Professional Diagnostic Issues Psychiatrists Misdiagnosis	5	<ul style="list-style-type: none"> <li>• “Psychiatrists diagnosing after a very short time without consultation with the clinician who has been working with the client.”</li> <li>• “Having to change my diagnosis to match the psychiatrist. The psychiatrist’s diagnosis ‘trumps’ the therapist’s.”</li> <li>• “I often receive clients already assessed by someone else. These people are sometimes married to a diagnosis that is questionable at best...”</li> </ul>

Table 21, continued

*Themes from responses to item 2 in Section IV of the UPDSM*

Themes	<i>n</i>	Supporting Quotes
Training Issues	3	<ul style="list-style-type: none"> <li>“Working with preschoolers and having to diagnose where there is limited training and research to support doing so.”</li> </ul>
Practice Setting Issues K-12 University Public Agency	3	<ul style="list-style-type: none"> <li>“Schools benefit from students who are under Individual Education Plans because of the federal funding they receive for children with special needs...A diagnosis has to be given in order for services to be received (and funded)...I believe if the system did not require these heavy diagnoses such as anxiety and depression as a requirement for reimbursement, we would see a drastic decline in the prevalence of these ‘conditions...’”</li> <li>“Outpatient mental health clients often need to be seen and need to be helped, but do not meet the full clinical requirements for the diagnosis area that designates the appropriate track for treatment...”</li> </ul>

*Note. Some respondents listed more than one ethical dilemma. Both responses were accounted for when appropriate and thus the total n is greater than the actual number of respondents to this question.*

### *Post hoc analyses*

While analyzing data for the six research hypotheses, some significant and noteworthy findings not related to the hypotheses were uncovered. While testing research hypothesis 2, two significant correlations were found that were not associated with any hypotheses. When comparing participants' perceptions about the adequacy of their training (items 2 and 6 in Section III of the *UPDSM*), a positive correlation was found between those who agreed with the statement that their graduate program adequately prepared them for utilizing the *DSM* (item 2) with their answers to item 6, that asked the participant to rate their agreement with the statement that their graduate program adequately prepared them to diagnose accurately ( $r(155) = .451$ ,  $p < .01$ ,  $r^2 = 0.203$ ). This correlation indicated that those who agreed that their courses adequately taught them the *DSM*, also adequately taught them how to diagnose clients accurately. The reverse proved to be correlated as well. That is, those who agreed that their training in diagnosis was adequate, also agreed their training in utilizing the *DSM* was adequate ( $r(145) = .349$ ,  $p < .01$ ,  $r^2 = 0.122$ ). The effect sizes in each comparison were small (.203 and .122) indicating that approximately 20% and 12% of the variance was shared by the two variables.

The next notable finding not included in the hypotheses was uncovered while testing hypothesis 5. A significant correlation was found between the responses to questions 17 and 20 ( $r(219) = .548$ ,  $p < .01$ ,  $r^2 = .300$ ) indicating that there is a positive linear relationship between those who agreed that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse clients accurately also agreed that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose women accurately too. A small to medium effect size (.3) was noted indicating 30% of the variance was shared by the two items.

After analyzing the data for research hypothesis 6, of note was that several of the respondents (11) indicated by written response they have no problems or ethical dilemmas related to diagnosis or using the *DSM* but instead had dilemmas regarding privacy laws or other issues faced by LPCs in practice. Although these responses were not considered when analyzing the qualitative data, the frequency of these responses warranted a mention in this section.

Significant findings were also uncovered when analyzing the data as a whole. The first significant correlation of note was between two items concerning respondents' opinions regarding components of training relevant to diagnosis and the *DSM*. Items 18 and 25 in Section III of the *UPDSM* made up the data used in this correlation. Item 18 asked the respondent to rate their agreement with the statement that CACREP accredited programs should increase the amount of coursework dedicated to diagnosis/*DSM* and item 25 asked the respondent to rate their agreement with the statement that counselor education programs should include a course in psychopharmacology. A significant, positive correlation was found between items 18 and 25 ( $r(219) = .609, p < .01, r^2 = 0.370$ ). This correlation suggests that there was a positive relationship between the participants who thought not only should CACREP increase their course requirements in diagnosis/*DSM*, but counselors should receive additional training in psychopharmacology. The effect size in this case was small to moderate at .370, indicating that 37% of the variance was shared between the two variables.

Significant, positive correlations were also found when comparing items 13 and 22 with items 18, 25, and 26 in Section III of the *UPDSM*. Item 13 asked the respondent to rate their agreement with the statement that they are practicing from a multicultural perspective and item 22 asked about their agreement with the statement that they practice from a wellness perspective when diagnosing clients. All correlations were significant in comparison with these two items.

Item 13 was significantly correlated with items 18 ( $r(219) = .475, p < .01, r^2 = .226$ ), item 25 ( $r(219) = .700, p < .01, r^2 = .490$ ), and 26 ( $r(219) = .699, p < .01, r^2 = .489$ ). Effect sizes in this case (.226, .490, and .489) were small to medium, indicating 22.6%, 49.0% and 48.9% of the variance was shared between the variables. Therefore, a significant positive linear relationship between LPCs identifying themselves as keeping a multicultural perspective when they diagnose, and their beliefs that CACREP should increase diagnosis/*DSM* course requirements, that counselors be taught a course in psychopharmacology, and that counselors should be able to be reimbursed by Medicare despite its requirement to diagnose clients. Notable positive significant relationships also existed when comparing item 22 with items 18 ( $r(219) = .312, p < .01, r^2 = .097$ ), 25 ( $r(219) = .559, p < .01, r^2 = .312$ ), and 26 ( $r(219) = .572, p < .01, r^2 = .327$ ). Effect sizes in this case (.097, .312, and .327) were small to medium, indicating 9.7%, 31% and 33% of the variance between the items was shared. This indicates a relationship between LPCs identifying themselves as keeping a wellness perspective when they diagnose, while also agreeing with the notions of increased course requirements in diagnosis/*DSM*, psychopharmacology, and Medicare reimbursement.

Noteworthy as well, was the significant positive correlation between items 13 and 22 ( $r(219) = .616, p < .01, r^2 = .379$ ), indicating a strong relationship between those identifying themselves as practicing from a multicultural perspective and a wellness perspective when diagnosing clients. The effect size (.379) in this instance was moderate, indicating that 37.9% of the variance was shared by the two variables.

#### *Post hoc reliability analysis*

Cronbach's alpha statistic was calculated for items 1-26 in Section III of the *UPDSM* to measure the reliability of that section of the instrument. Items were separated into three groups to



assess internal consistency reliability. The groups were separated by the wording of the statements. That is, the first category contained affirmatively-worded statements that the participants were asked to rate their agreement with, the second category contained negatively-worded statements that the participants were asked to rate their agreement with, and the third category contained those statements which were neither affirmative nor negative, but asked the participants to rate their agreement with statements reflective of personal beliefs about counseling, decision-making, or identification with a theoretical orientation. The 13 affirmative statements scored  $\alpha = .698$ , the 9 negative statements scored  $\alpha = .815$ , and the neutral statements scored  $\alpha = .324$ . These results indicate that the affirmatively-worded items were reliable, the negative statements were quite reliable, and the neutral statements had low reliability.

### **Summary**

This chapter presented the results of this research study. Results for research hypotheses 1-6 were reported, as were post hoc findings of interest. Research hypothesis 1 stated that a majority of LPCs diagnose clients using the *DSM-IV-TR*; that those LPCs will cite billing-related reasons as the most important reason they diagnose; and that those LPCs who do not currently diagnose will cite legal reasons as their most common reason why not. This hypothesis was partially supported, as it was shown that indeed a majority of the participants in this study did diagnose clients and use the *DSM*, and LPCs cited billing-related issues as their most important reason why they diagnose. However, the last part of research hypothesis 1 was not supported as those who indicated that they do not diagnose clients cited legal reasons the least out of all the choices presented.

Research hypothesis 2 stated that LPCs will significantly agree with the statements that their training was adequate to utilize the *DSM*, and that their training was adequate to diagnose

accurately; that a majority of LPCs will have had at least one graduate course devoted to *DSM*/diagnosis; and that a majority of LPCs will have had at least one continuing education hour devoted to *DSM*/diagnosis. This hypothesis was also partially supported by the data analyses. A majority of LPCs did complete at least one graduate course focused on diagnosis/*DSM* and completed at least one hour of continuing education focused on diagnosis/*DSM*. The data did not support the assertion that LPCs significantly agreed that their training was adequate to utilize the *DSM*, but the data did support the assertion that LPCs significantly agreed that their training was adequate to diagnose accurately.

Research hypothesis 3 stated that LPCs who completed at least one course in *DSM* instruction and diagnosis will rate the adequacy of their training higher than those who completed fewer courses on that topic. In this case, the data supported the hypothesis, and those LPCs who had at least one graduate course in diagnosis/*DSM* rated both their training to utilize the *DSM* and their training to diagnose accurately significantly higher than those who had no courses on those topics.

Research hypothesis 4 stated that LPCs' scores rating a significant identification with the wellness perspective would be positively correlated with their scores indicating whether or not their theoretical orientation plays a large part in their decision to diagnose a client. No significant correlations were found, and research hypothesis 4 was not supported by the data.

Research hypothesis 5 stated that LPCs' scores indicating their self-reported identification as multiculturally competent counselors and their self-reported use of a multicultural perspective when diagnosing clients, would be positively related to their scores indicating belief that the *DSM* does not adequately present disorders in such a way as to allow

accurate diagnosis of culturally diverse and female clients. No significant correlations were found in this instance, and research hypothesis 5 was not supported.

Research hypothesis 6 stated that LPCs' descriptions regarding the most frequent ethical dilemma they encounter due to diagnosing clients will center on financial issues. Out of the 219 respondents who reported that they currently diagnose clients, 140 chose to answer question 2 in Section IV of the *UPDSM*. The data for this hypothesis were analyzed with grounded theory techniques and it was determined that the most frequently discussed ethical dilemma did in fact center on financial issues. Thus, research hypothesis 6 was supported by the data.

Post hoc analyses were also performed in light of some of the results when testing the hypotheses, and after analyzing the data as a whole. Several significant, positive, correlations were found. First, it was noted that those who agreed that their courses adequately taught them the *DSM*, also agreed that their training also adequately taught them how to diagnose clients accurately.

Next, it was noted that there is a positive linear relationship between those who agreed that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse clients accurately also agreed that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose women accurately too.

The next post hoc analysis was noted when analyzing hypothesis 6. In that analysis it was noted that 11 of the written comments to the question about ethical dilemmas in regards to diagnosis and the *DSM* indicated that they never have any ethical dilemmas in regards to diagnosis.

Another significant post hoc finding was between two items concerning respondents' opinions regarding components of training relevant to diagnosis and the *DSM*. The items asked

the respondents to rate their agreement with the statement that CACREP accredited programs should increase the amount of coursework dedicated to diagnosis/*DSM*; and to rate their agreement with the statement that counselor education programs should include a course in psychopharmacology. A significant, positive correlation was found suggesting that there was a positive linear relationship between the participants who thought not only should CACREP increase their course requirements in diagnosis/*DSM*, but counselors should receive additional training in psychopharmacology.

A significant relationship was also found when correlating statements concerning participants' perceptions of their identification with both the wellness model and multicultural perspectives when diagnosing clients, and their opinions about an increase in CACREP standards to require additional training in diagnosis and the *DSM*, whether or not counselor education programs should include a course in psychopharmacology, and whether or not counselors should be providers for Medicare despite its requirements to diagnose clients. These data analyses resulted in significant positive relationships. It was also of note that there was a significant positive correlation between those who agreed that they diagnose from a multicultural perspective and those who practice from a wellness perspective.

The post hoc reliability testing results of the 1-26 item scale in Section III of the UPDSM were mixed. While the statements which were worded affirmatively and negatively had adequate reliability scores, the neutral, opinion seeking statements' alpha score had low reliability.

Chapter 5 examines these results further and discusses the implications of the findings for LPCs and the counseling profession.

## **CHAPTER FIVE**

### **DISCUSSION**

This chapter summarizes and discusses the findings in this research study. Limitations and significance of the study, implications for counselors, recommendations for future research, and conclusions are also discussed.

#### **Purpose of the Study**

The purpose of this study was to identify LPCs' attitudes about and perceptions of their preparation to diagnose and utilize the *DSM*; to identify prevalent ethical dilemmas encountered by LPCs when diagnosing clients; to measure LPCs' perceived influence their theoretical orientation may have over their decision to diagnose clients; and to identify any perceptions of gender or cultural bias LPCs may have about the *DSM*. This study was based on a study by Mead et al. (1997) in which community mental health counselors (CMHCs) were surveyed about their perceptions of and how they used the *DSM-III* in practice.

This study, in contrast to Mead et al., surveyed LPCs, and focused specifically on training, theoretical influence, sex, and multicultural counseling issues when diagnosing clients. This study was also based on some non-empirical literature (see Eriksen & Kress, 2005; Hansen, 2003; Ivey & Ivey, 1998, 1999; Remley & Herlihy, 2007) in which scholars suggest potential conflicts, advantages, and disadvantages to the counseling profession when learning and utilizing diagnosis procedures.

#### **Discussion of the Findings**

Counselors diagnose clients in a variety of settings. School counselors, college counselors, counselors in private practice, counselor educators, and counselors employed in for-profit and not-for-profit organizations, government agencies, and hospitals must have knowledge

of the *DSM* and the process of diagnosis (Geroski et al., 1997; Remley & Herlihy, 2007). Financial reimbursement, communication with other healthcare professionals, and ensuring appropriate mental health care for clients or students are all important functions of diagnosis and the *DSM* (Eriksen & Kress, 2006; Remley & Herlihy).

Scholars have expressed concern about several issues related to diagnosis. Diagnosing clients inaccurately or unnecessarily because of developmental, cultural, or gender-specific issues occurring in the client's life (e.g., Ivey & Ivey, 1998; Kress et al., 2005) is one concern. Also cited in literature are ethical concerns that arise for counselors who diagnose because of the reimbursement requirements by third-party payers or managed care companies (Braun & Cox, 2005; Danzinger & Welfel, 2001; Remley & Herlihy, 2007). Scholars also debate training concerns regarding how much emphasis should be put on the diagnostic role that counselors play in the mental health profession. Some propose that too much diagnostic emphasis will diminish the identity and paradigms of counseling as a profession (Hansen, 2003), while another discusses the need for further training of counselors in psychopharmacology (Ingersoll, 2000).

The "LPC Uses and Perceptions of the *DSM-IV-TR*" (*UPDSM*) was created to: 1) collect comprehensive demographic information about LPCs who currently diagnose and do not diagnose clients, 2) collect information about LPCs training in diagnosis and the *DSM*, 3) identify some of the reasons why LPCs do or do not diagnose clients, 4) measure the perceived adequacy of LPCs' training in diagnosis and the *DSM*, 5) measure LPCs' perceived level of influence their theoretical orientation has on their decision to diagnose, 6) measure LPCs' perceptions of whether or not the *DSM* presents disorders so culturally diverse and female clients may be diagnosed accurately, and 7) collect details of ethical dilemmas that may occur when

LPCs diagnose clients. Discussion about the descriptive statistical findings, the six research hypotheses, and post hoc findings follow.

### *Descriptive Statistics*

Some findings stood out among the descriptive statistics that were calculated for the 26 items in Section III of the *UPDSM*. In examining the highest means, the statements “I am a multiculturally competent counselor,” “The university graduate courses I completed adequately taught me the organization and structure of the *DSM* so I may understand and use it in practice,” and “My licensing supervisor appeared to be in favor of diagnosis and using the *DSM*” were rated the highest in participant agreement. Participants overall disagreed most strongly with the statements, “Using the *DSM* in practice conflicts with my professional identity as a counselor,” and “I attribute my decision to diagnose or not diagnose clients to my theoretical orientation.” Large standard deviations were found in 12 of the 26 items, indicating the diverse range of agreement with those items. Notably, items 25 and 26, which read, “I think counseling accreditation standards should require training in psychopharmacology,” and “I believe LPCs should be Medicare and Medicaid providers despite requirements to provide client diagnoses,” respectively, scored high standard deviations (greater than 2.00), and the responses to these items were almost evenly split between those who agreed with this statement and those who disagreed with this statement.

These results are notable because they describe a generally conflicted population. The data suggest that the participants view themselves as embracing counseling paradigms, because they in general self-identify as multiculturally competent. However, these results also suggest that practicing diagnosis does not conflict with the participants’ professional identity, that their theoretical orientation does not influence their decision to diagnose, and that their training was

rather adequate to use the *DSM*. The participants could not agree that they should be providers for Medicare, a federal insurance body that does not allow for counselors to be providers, and Medicaid, state insurance bodies that do not currently reimburse professional counselors in all states (ACA, 2008). The respondents also had difficulty agreeing that counseling programs should be training counselors in psychopharmacology.

The literature reflects this diversity of opinion. For example, Seligman (1999), Ingersoll (2000), and the 2005 ACA *Code of Ethics* recognized and endorsed the growing trend in diagnosis and were proponents of increased and more diverse training requirements in diagnosis for counselors. Ivey and Ivey (1998, 1999) and Hansen (2003) suggested that counselors remain focused on developmental paradigms in counseling and de-emphasize the role diagnosis plays in the counseling profession. ACA, however, strongly endorses and lobbies the U. S. Congress to pass legislation allowing LPCs to be providers for Medicare and Medicaid clients (ACA, 2008).

#### *Discussion of findings for Research Hypothesis 1*

Research hypothesis 1 stated that a majority of LPCs diagnose clients using the *DSM-IV-TR*; that those LPCs will cite billing-related reasons as the most important reason they diagnose; and that those LPCs who do not currently diagnose will cite legal reasons as their most common reason why not. The results of the hypothesis testing supported two of the three portions of this hypothesis. A majority of the respondents indicated that they indeed diagnose clients using the *DSM*, and the most cited reason for diagnosing clients according to the results was financially driven.

The results of the first portion of research hypothesis 1 coincide with Mead et al.'s (1997) national study 11 years ago, which indicated that a majority of the respondents or their co-workers practiced diagnosis, and were doing so primarily to get payments from insurance



carriers or other third-party payers. These results are consistent with Eriksen and Kress's (2006) acknowledgement of growth in the practice of diagnosis, and Braun and Cox's (2005) assertion of a growing need of counselors to rely on managed care companies for financial reimbursement.

Results of hypothesis 1 also indicated that legal reasons were not the predominant reason why LPCs did not diagnose. This portion of the hypothesis was formulated after the results from Mead et al.'s (1997) study which indicated that 53% of their participants agreed they would diagnose if they were not required to do so. Therefore, it was reasoned that Mead et al.'s participants who did not diagnose may be unable to do so due to legal restrictions. However, the results did not support this reasoning, and of the 84 participants who indicated that they do not diagnose, 72 of them indicated that at least one of the reasons why they do not diagnose is because their jobs do not require them to diagnose. The 16 respondents who commented on their reasons for not diagnosing said they did so because they either did not accept insurance; they began counseling before counselors used the *DSM* in practice; their counseling specialty did not require diagnosis, or they did not want to risk or did not believe in labeling clients. The responses that the participants gave in the comments section of this question were in accord with some of the disadvantages of diagnosis that are cited often in the literature. For example, Ivey and Ivey (1998, 1999) strongly emphasize counseling techniques that embrace the framing of mental disorders into developmental crises. Utilizing insurance and managed care programs to get paid for services is a popular practice today (Braun & Cox, 2005), and practitioners who do not rely on this method of payment in private practice, can choose whether or not they will diagnose clients. Rogers' (1945) person-centered theories of counseling emphasized a rigorous non-judgmental and anti-diagnostic approach, which would account for those participants who were trained in this era attributing their decisions to not diagnose to their pre-*DSM* era training.

### *Discussion of findings for Research Hypothesis 2*

Research hypothesis 2 stated that LPCs will significantly agree with statements that their training was adequate to utilize the *DSM*, and that their training was adequate to diagnose accurately; that a majority of LPCs will have had at least one graduate course devoted to *DSM*/diagnosis; and that a majority of LPCs will have had at least one continuing education hour devoted to *DSM*/diagnosis. A portion of this hypothesis was supported by the results.

Although a majority of LPCs did have at least one course and one continuing hour of education focused on diagnosis and the *DSM*, the results of the chi square test showed that the affirmative answers given to the statement that their training was adequate to utilize the *DSM* were able to be accounted for by random chance. However, a chi square test did indicate that there were a significant number of respondents who agreed that their graduate training was adequate to diagnose clients.

These results support the idea that a majority of LPCs get some training in diagnosis and the *DSM*; however, the results also suggest that their training may not be adequate when it comes to using the *DSM* as a tool of diagnosis. Conversely, the participants did significantly agree that their training in the process of diagnosis was adequate. This discrepancy implies that perhaps there is a gap in the training between what each diagnosis is and what the implications are for clients, and how to utilize the *DSM* as a tool to diagnose differentially. There is little literature to support this finding, but perhaps Hansen's (2003) assertion that counselors may over-identify with medical models of thinking if not properly trained could be inverted to say that counselors-in-training could also under-identify with the *DSM*; thus, the perception that the *DSM* is of minimal importance to counselors enables counselors to neglect taking seriously the organization and structure of the book itself. Another assertion could be reasoned that due to the over-

emphasis in training on all of the problems with the manual itself—it is judgmental, socially stigmatic, reductionistic, and does not take contextual situations into enough consideration (Eriksen & Kress, 2006)—LPCs who responded to this survey, do not hold a favorable view of the manual or believe it harmful to clients, and in turn do not feel invested enough in the need to study the manual.

### *Discussion of findings for Research Hypothesis 3*

Research hypothesis 3 stated that LPCs who completed at least one course in *DSM* instruction and diagnosis will rate the adequacy of their training higher than those who completed fewer courses on that topic.

The results of the hypothesis testing in this case were significant. There was a significant positive relationship between participants who completed at least one course focused on diagnosis and the *DSM* and their agreement that their training was adequate to diagnose and utilize the *DSM* effectively. Mead et al. (1997) called for increased training in diagnosis and Hohenshil (1993) believed that a trend existed of growing acceptance in diagnostic training. These studies, conducted 11 and 15 years later respectively, suggest that Mead et al.'s and Hohenshil's predictions were correct. In fact, a minority of the participants in this study who diagnose clients (n=11), admitted they had no graduate training in diagnosis, and the majority of those who did admit to having some graduate training in diagnosis agreed that their training was more adequate than those who did not. Therefore, understanding both the process of diagnosis and the *DSM* itself increases when graduate training is included in the required coursework for counselors. Seligman (1999) called for increased training in diagnosis, and CACREP (2001) requires accredited counseling program graduates to be proficient in understanding human abnormal behavior.

The results of research hypothesis 3 support the literature that calls for training in diagnosis and the *DSM*, as increased courses may lead to increased perceptions of the adequacy of training. However, debate exists between what kind of training should be given and what the consequences of that training may be. As mentioned previously, Ingersoll (2000) calls for training in pharmacology, while Hansen (2003) fears too much training in diagnosis can lead to counselors' over-identification with the medical model that he believes the *DSM* represents.

#### *Discussion of findings for Research Hypothesis 4*

Research hypothesis 4 stated that LPCs' scores indicating their identification with the wellness perspective would be positively correlated to scores indicating that their theoretical orientation plays a part in a LPC's decision to diagnose a client.

The results in this case did not support the research hypothesis. Mead et al.'s (1997) study did not directly question participants on this specific topic; however, they did report their surprise at marriage and family therapists who simultaneously held an unfavorable view of the *DSM* and practiced diagnosis. In this study, it was noted that a strong identification with the wellness model did not mean that theoretical orientation influenced their decision to diagnose clients. Therefore, this study mirrored the results of Mead et al.'s because this discrepancy between a practitioner's theory of choice and decision to diagnose is reinforced by this result. The descriptive statistics described in this study reflect these results as well. Participants overall did not agree that their theoretical orientation contributed to their decisions to diagnose clients (see Table 13).

The results of the test of research hypothesis 4 suggest that despite counselors' theoretical identification, the process of diagnosis appears to be done as some separate part of the counseling process. Because this question was asked only to those participants who indicated

that they diagnose clients (n=219), it appears that somehow counselors are able to separate themselves from their developmentally derived wellness theoretical orientation, which conflicts with the process of diagnosis, in order to fulfill an obligation by an outside party to diagnose clients. It is possible that the literature supports this finding, as Hansen (2003) suggested that when diagnosis is taught to counselors-in-training, it be taught as an "...important survival skill...." He suggested that when this approach is taken, "...the counseling student leaves the classroom with diagnostic skills but also has a fundamentally humanistic professional identity and the ability to think critically about the diagnostic enterprise (pp. 102-103)."

#### *Discussion of findings for Research Hypothesis 5*

Research hypothesis 5 stated that LPCs' scores indicating their self-reported identification as multiculturally competent counselors and their self-reported use of a multicultural perspective when diagnosing clients, would be positively related to their scores indicating belief that the *DSM* does not adequately present disorders in such a way as to allow accurate diagnosis of culturally diverse and female clients.

The results of the hypothesis tests were not significant. The *ACA Code of Ethics* (2005), states that counselors must be multiculturally sensitive when diagnosing clients. This code implies that the *DSM* must be looked at from a different perspective, and is not naturally multiculturally sensitive. However, the participants in this study seemed not to agree with this judgment. That is, there was no relationship between those LPCs who identified as either multiculturally competent or using a multicultural perspective when diagnosing clients, and their perceptions of whether or not the *DSM* allows for accurate diagnosis of culturally diverse and female clients. Several reasons may account for these results. It is possible that these participants, as Hansen (2003) or Kress et al. (2005) explain it, were not trained to look critically

enough at the implications of a *DSM* diagnosis, and became somewhat indoctrinated into the medical model perspective of viewing disorders listed in the *DSM* as a universal, individualistic, phenomenon, and not in the context of multicultural norms. It is also possible that, in contrast to Smart and Smart (1997), the participants in this instance believed that the cultural discussions and appendices intended to include multicultural issues within the *DSM* are sufficient to make multiculturally sensitive diagnoses, as required by the *ACA Code of Ethics* (2005).

#### *Discussion of findings for Research Hypothesis 6*

Research hypothesis 6 stated that LPCs' descriptions about the most frequent ethical dilemma they encounter due to diagnosing clients would center on financial issues. After analyzing the data, this predominant theme emerged, and the research hypothesis was supported. This hypothesis was based on Mead et al.'s (1997) study that reported that many of their participants admitted to knowledge about intentional misdiagnosis for the purpose of reimbursement. Fitting a *DSM* diagnosis to a client and justifying that diagnosis to third-party payers was the most frequently cited diagnosis-related ethical dilemma experienced by the respondents. Over- and under-diagnosis was discussed and admitted to by several respondents. This practice, as described by the respondents, usually involved the LPC either feeling forced to diagnose clients with disorders more severe so insurance companies deem the counseling reimbursable, or they are careful to under-diagnose clients with a diagnosis just severe enough to warrant counseling for a third-party payer while at the same time sparing the client the possible problems associated with being labeled with a diagnosis. Remley and Herlihy (2007) referenced this practice, while Danzinger and Welfel (2001), who surveyed counselors on their perceptions of the ethical dilemmas they encounter while diagnosing managed care clients, also reported a prevalence of misdiagnosis for the sake of income.

Labeling clients was another frequently mentioned concern among the respondents, who expressed hesitation to diagnose a client disorder for fear it will label them for life. Respondents specifically mentioned military applications, life insurance, and employment rejections all being the repercussions of being labeled with a mental illness. This conflict concerning labeling for life would often overlap with why respondents in this survey would admit practicing under-diagnosis, giving clients the least severe diagnosis so that this diagnosis would not interfere with the client's ability to obtain services or gain employment. Remley and Herlihy (2007) discussed the ramifications of labeling and identified all of the above possibilities and scenarios possibly detrimental to the client cited by the participants in this study.

Some population-specific themes emerged as well. Marriage and family counselors felt conflicted by having to diagnose someone in the relationship in order to justify couples counseling. Another example was diagnosing children and adolescents. This client population was also distinct because some participants believed children were either too often diagnosed with some form of attention deficit disorder or pervasive developmental disorders. The literature has documented these dilemmas as well, with no clear cut resolutions, except to protect the welfare of the client while the counselor remains ethically responsible (Remley & Herlihy, 2007). Some propose the counselor remain aware of the implications of the diagnosis on the relationship between the counselor and the couple, and the ramifications of a diagnostic label on the individual client (Eriksen & Kress, 2005).

Theoretical beliefs also had a place in the participant responses. That is, several respondents stated they did not believe that diagnosis had any place in counseling; however, these respondents also indicated they participated in diagnosis when required by an outside source. Thus, despite their theoretical beliefs about counseling, they were still able to diagnose

others, setting aside those beliefs in order to fulfill the requirements of their job or the requirements of the reimbursing party. One aspect of these results is heavily supported in the literature in that many scholars advocate for Rogers' (1945) non-judgmental, non-diagnostic positions; however, as Braun and Cox (2005) point out, it is virtually impossible today to practice mental health counseling and not be somehow affected by the regulations of managed care companies which insist on a diagnosis in order to reimburse the counselor for services.

Some LPCs specified that the ethical dilemmas they encountered related to diagnosis were based on legal issues. Participants expressed concerns about the possible negative impression a diagnosis can give in a court situation, and how counseling sessions that may involve discussions about a mental illness could be used in court cases. The literature concurs with this dilemma (Eriksen & Kress, 2005; Remley & Herlihy, 2007) suggesting that counselors who are involved in court disputes can be placed in a difficult position because not all states protect client-counselor communication, and oftentimes the privileged information (including any diagnoses) can be waived only by the client or a judge's order. Also discussed is the difficulty in tactfully and appropriately informing clients of this possible limit to confidentiality; however, a balance must be achieved in discussing these limits to confidentiality as to not scare clients so they do not feel safe revealing information to the counselor for fear of it coming out in court (Eriksen & Kress; Remley & Herlihy).

Another emergent theme was LPCs' concerns about other mental health professionals whose diagnosis conflicts with theirs. Some reported that they faced dilemmas when clients came to them misdiagnosed by other mental health professionals, and felt ethical dilemmas about diagnosing when psychiatrists' diagnosis often "trump" the diagnosis the LPC may give. This phenomenon does not appear to be specifically targeted in the counseling literature. However,



more than one meaning can be extrapolated from these participants' answers. One could first reason that the participants felt the other mental health professional intentionally misdiagnosed the client. The literature supports the phenomenon that counselors will engage in misdiagnosis for reimbursement purposes (Braun & Cox, 2005; Danzinger & Welfel, 2001). However, one could also reason that the participants were concerned by instances of misdiagnosis by another mental health professional because they believed the other mental health professional innocently diagnosed inaccurately. This explanation is not present in counseling literature, and should be the focus of future research. Another phenomenon not addressed in the literature is how an LPC's diagnosis is viewed by other mental health professionals. One participant described his/her diagnosis of a client as being "trumped" by a psychiatrist. Again, one may reason different implications of this statement. One may reason that the participant was referring to a professional slight—that the LPC diagnosis is not viewed as qualified or as accurate as the M.D. One participant included the point that he/she spent more time with the client than the psychiatrist, and resented that his/her opinion was not considered. One could also reason that the participant intended to mean that if their diagnosis was going to be disregarded in some way, why would the participant want to unnecessarily diagnose a client and perhaps cause some harm to the relationship? These may be topics for future research, as they are mostly not discussed in the counseling literature. Literature exists however, that does reinforce the idea of potential harm to the client because of diagnosis. Remley and Herlihy (2007) for example, suggested that being diagnosed with a disorder may cause people to act how they perceive that diagnosis should manifest itself in their behavior. Thus, misdiagnosis, whether intentional or not, can cause harm to a client.

Some LPCs expressed concern over their training not being adequate enough to diagnose developmental disorders. Layne (2007) supported this participant's perception by acknowledging that, "...virtually no attention has been paid to providing training for counselors assisting with preschoolers with autism and their siblings" (p. 110).

Others expressed concern over their difficulties in the constraints of their job setting and diagnosing clients. Some participants believed their jobs depended on the number of or the particular diagnosis given to school-aged children in order to benefit the school financially. Another respondent discussed the position in his/her workplace wherein services were denied to people who do not meet certain diagnostic criteria but who still needed help. Although these two situations overlap with the theme of diagnosis for reimbursement, a distinction was made as to the settings in which they occurred. These responses illustrate the dilemma of diagnosis experienced in a variety of settings, including fundamental institutions such as schools. Therefore, the literature that discusses the ethical dilemmas experienced by those who are forced to diagnose in order to get financial reimbursement may support the dilemma expressed here (see Braun & Cox, 2005; Danzinger & Welfel, 2001).

#### *Discussion of Post Hoc Findings*

Post hoc findings in this study were examined as they emerged from hypotheses testing, and after analyzing the data as a whole. Significant, positive relationships existed between several variables suggesting several conclusions.

A positive, significant, relationship was found between items 2 and 6 in Section III of the *UPDSM* asking the participants to rate the adequacy of their training to utilize the *DSM* also agreed that their training was adequate to diagnose. This result may be accounted for by the lack of literature that examines the differences between the process of diagnosis and the utilization of

the *DSM* as a manual to follow to diagnose. It could be that the respondents in this case saw no real difference in the two statements. However, this result does coincide with Mead et al.'s (1997) findings that the counselors surveyed in that study overall rated their skill rating in using the *DSM* as a 7.85 on a scale of 1-10 (1 being the least skilled and 10 being the most skilled).

It was also noted that those who agreed that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse clients accurately also agreed that the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose women accurately too. These results are supported by the literature, as several scholars have asserted *DSM* bias in both of these areas (Eriksen & Kress, 2005; Kress et al., 2005; Remley & Herlihy, 2007).

The next post hoc analysis was noted when 11 of the written comments to the question about ethical dilemmas in regards to diagnosis and the *DSM* indicated that participants never have any ethical dilemmas in regards to diagnosis. These responses may be accounted for because these participants have justified the practice of diagnosis in such a way that they feel no ethical dilemmas when diagnosing clients despite their possible identification with developmental theories. It can also be suggested that these practitioners have internalized a medically modeled method of practicing counseling as discussed by Hansen (2003), and experience no ethical dilemmas because they do not subscribe to developmental theories.

Another significant positively correlated post hoc finding was between two items that asked the respondents to rate their agreement with the statement that CACREP accredited programs should increase the amount of coursework dedicated to diagnosis/*DSM*; and to rate their agreement with the statement that counselor education programs should include a course in psychopharmacology. Ingersoll (2000) called for counselor education programs to integrate

psychopharmacology, and despite CACREP's (2001) accreditation requirements to include diagnostic training, the results in this case suggest that those who believe an increase in diagnostic training is warranted, believe that should include training in psychopharmacology.

Significant relationships were found when correlating statements concerning participants' perceptions of their identification with both the wellness model and multicultural perspectives when diagnosing clients, and their opinions about increasing CACREP standards to require additional training in diagnosis and the *DSM*, whether or not counselor education programs should include a course in psychopharmacology, and whether or not counselors should be providers for Medicare despite its requirements to diagnose clients. These data analyses resulted in significant positive relationships. That is, there was a positive correlation between counselors who identified themselves as using a multicultural perspective when diagnosing, and increasing training, including a psychopharmacology course, and counselors becoming Medicare and Medicaid providers. There was also a positive correlation between counselors who identified themselves as using a wellness perspective when diagnosing, and increasing training, including a psychopharmacology course, and counseling becoming Medicare and Medicaid providers. These correlations indicate that perhaps taking a multicultural or wellness perspective in counseling also means increasing counselors' training and increasing counselors' ability to access and provide care to a wider range of populations.

### **Limitations and Delimitations**

Limitations to this study included sampling error. Because participation in the *UPDSM* questionnaire was voluntary and it was distributed to ACA members and LPCs listed in public internet directories in the Southern region of the United States, there was a possibility that those who respond to the survey would not be a representative sample of LPCs. However, despite the

target area of participants, there were a considerable number of participants who reported they held additional licenses in states outside of the target area. Specifically, Delaware, Idaho, Illinois, Kansas, Massachusetts, Michigan, New Jersey, New York, North Carolina, Ohio, Oklahoma, Oregon, and Washington D.C. were all named by the participants.

There was also a possibility that those who responded to the survey did so without meeting the requirements of the survey to participate. However, in an attempt to correct for this possibility, the respondents who answered that they had no counseling license or who possessed the first of a two-tiered system of licensure (as is the case in Kentucky) had their answers eliminated from the response pool.

Response bias may have occurred due to the nature of the questionnaire—that is, because the survey contained questions that asked counselors about the adequacy of their training, respondents may have been reluctant to admit any inadequacies. Bias may have occurred by virtue of the respondents chosen in that they must have had access to the internet and email, and must have been able to afford the dues associated with membership in ACA or in including their information on a public internet LPC listing. Concerns for privacy and use of the internet to conduct a survey could have intruded upon a potential participant’s decision to complete the survey.

An additional limitation of the survey was in the question construction. Despite review by expert panels to support content validity, there was the possibility that the questions did not measure what was intended, thus reducing the survey’s reliability.

A limitation may have been present in the gender composition of the expert panel reviews and primary researcher. Of the ten experts who participated in the two expert panel reviews, only one panel member was male, and the primary researcher is female. This is pertinent in that the

study explored aspects of gender bias, and the only males involved in the creation or review of this research study were the dissertation committee chair and one member of the expert panel review. However, a majority of counselors who responded to the survey (approximately 71%), much like the gender composition of practicing counselors, were female.

Another limitation was that the *UPDSM* questionnaire did not measure LPCs' opinions over time. Opinions may have changed due to policy or legal challenges, participants' experiences, and their mood and feelings at the time of their response.

A delimitation of this survey was that the counselors chosen to participate were licensed to practice by their respective state licensing boards, which requires some years of supervised clinical experience. Therefore, the most recent graduates of counseling training programs, whose opinions may have been more reflective of the current trends in teaching diagnosis and the *DSM*, were not measured. An additional delimitation was that the counselors chosen had no maximum years of practice—again not focusing on the newest counselors, but ones who had been in the field for at least the minimum number of years required before licensure.

### **Implications for LPCs and Counselor Educators**

The results of this study were intended to bring awareness to professional counselors and counselor educators about the advantages and disadvantages associated with diagnosis and using the *DSM*. Building on Mead et al.'s (1997) study, this study was also intended to further scholarly discussion about how diagnosis is being integrated into the counseling profession, and how counselors' professional identity, which involves subscribing to developmental/wellness oriented theories, is distinct from other professions.

The results of this study suggest that LPCs have a difficult dilemma when diagnosing clients. Some research has suggested that LPCs feel conflicted when deciding on a diagnosis for

financial reimbursement, because they recognize that the diagnosis could not only have negative ramifications for the client, but could also have negative ramifications for the counselor if that client's diagnosis is not deemed reimbursable from the insurance company (Danzinger & Welfel, 2001). It is therefore important for counselors to consider some way to reconcile the ethical dilemma—assigning a diagnosis to a client while not breaking the law by intentionally under- or misdiagnosing clients while at the same time remaining aware of the multicultural, contextual, and developmental issues happening in the client's life.

The results of this study also suggest that LPCs feel more adequate to diagnose when they have more training. Thus, LPCs who do not feel adequately trained to diagnose, whether it be certain types of disorders as classified in the *DSM*, or various client populations, may consider seeking continuing education hours on those topics. The ACA (2008) is actively lobbying for counselors to become Medicare providers in order to increase access to care for clients despite the requirements of Medicare to provide diagnoses for reimbursement. Therefore, it is possible that increased training in the *DSM* and diagnosis may become a requirement of counselor education programs in the future; and this in turn may push counselor educators to come to some consensus on a comprehensive and integrative system of teaching this subject while still preserving the values that distinguish counselors from other mental healthcare professions.

### **Implications for Future Research**

Numerous questions and opportunities for further research were raised in this study. The notable results of the descriptive statistics, of the hypothesis testing, and of the post hoc findings are discussed in this sub-section.

The descriptive statistics suggested LPCs strongly agreed with the statement identifying them as multiculturally competent. Further research might be done on how LPCs perceive and

define multicultural competence and how they incorporate those values into their counseling. The descriptive statistics also suggested that LPCs disagreed that their theoretical orientation had any bearing on their decisions to diagnose clients, or that their diagnosing clients conflicted with their professional identity. This view that a practitioner's developmental theory can be set aside when deciding whether or not that practitioner diagnoses clients, leads one to wonder about the internal processes at work when counselors justify diagnosing clients while identifying with a particular theory which may oppose diagnosis. Research may also be done further identifying and defining the split in opinions between counselors in regards to Medicare and Medicaid reimbursement; despite this split opinion, this is a lobbying priority of ACA (2008), the national professional organization of counselors.

The results of the six hypotheses suggested several areas that may warrant further research. First, respondents indicated that training in the *DSM*/diagnosis correlated with a higher perception of adequacy to diagnose and use the *DSM*. These results suggest that further research be done in how much training would be adequate so counselors may perceive themselves as very adequately trained in diagnosis and utilizing the *DSM*. Although some respondents identified themselves as multiculturally competent and practicing from a multicultural perspective when they diagnose, they did not indicate that they believed the *DSM* does not present disorders in order to diagnose women and culturally diverse populations accurately. This result indicates further research be done on what it means to practice from these perspectives and what internal processes are at work when LPCs remain multiculturally aware when diagnosing women and other culturally diverse clients. LPCs reported that one of their ethical concerns regarding diagnosis was their beliefs about how other mental health professionals perceived the diagnoses that they ascribed to their clients. Further research may be needed to explore how other mental



health professions view counselors' competence to diagnose. Another notable result was that a small percent (7.86%) of the respondents indicated they never experience ethical dilemmas related to diagnosing clients. In light of this result, further research may be done to explore how these counselors manage to avoid these ethical dilemmas.

Post hoc findings indicated that the LPCs who perceived themselves as practicing from a multicultural or wellness-oriented perspective, also agreed that training for LPCs in the areas of diagnosis and the *DSM* be increased, and that pharmacology be taught as well. These results suggest that further research be may be done on how those who view themselves as multiculturally and developmentally focused justify their view to increase training in diagnosis and psychopharmacology.

Also noted was the large number of associations (80) participants belonged to and certifications (45) held by the participants. These findings suggest further research could be done exploring the benefits for counselors who hold these various memberships and certifications, and what impact membership in or certification in these areas on those counselors' therapeutic approaches with their clients.

### **Significance of this Study**

LPCs' perceptions of the issues discussed in this study were significant academically, practically, and were significant for professional organizations. This subsection discusses the results to substantiate the significance of this study.

This study was significant academically because it contributed to the academy's knowledge about the need for more comprehensive or different issues emphasized when training counselors to diagnose or to use the *DSM* effectively as called for by Hansen (2003). The academy also benefits because this study may help to facilitate a discussion on how to guide

student counselors to utilize counseling theories and diagnose ethically despite the paradox between the act of diagnosis and developmental theories of counseling. Scholars have called for a continuation of discussions regarding closing the gap between diagnosis and the conflicts that it presents (Eriksen & Kress, 2006) to counselors who choose to practice it.

This study is significant practically because the results have real world applications. If counselors are troubled ethically by the cultural or gender bias that may exist in the *DSM*, perhaps pressure from professional counselors can initiate change in the future editions of the *DSM* to further incorporate cultural contexts into the nomenclature to better differentiate diagnosis (Kress et al., 2005). With a discussion of ethical dilemmas as they relate to insurance reimbursement, results of this survey may further build the case for change in managed care practices and facilitate ways to address the practice of misdiagnosis (Danzinger & Welfel, 2001).

This study is significant to professional counseling organizations like ACA because ethical codes and state licensure boards help to facilitate the public's understanding of counseling's distinct professional identity. Therefore, when attempting to ascertain the differences in their choice of mental health care providers, consumers can understand that counselors are distinct in theoretical ways from other helping professionals, yet are able to provide quality, expert service that will be covered by their insurance providers.

### **Conclusions**

There are several conclusions that may be drawn as a result of this study. First, results of this study suggest that the profession of counseling is still struggling to carve a niche for itself among other mental health professions who utilize medically-based theories regarding human behavior by vaguely integrating some diagnostic/*DSM* training into the counseling curricula. Although the counseling profession seeks to be inclusive, to recognize all people as individuals

capable of growth and change, and allow for the growth and development of coping skills for individuals at their own pace, ACA, the professional organization representing thousands of counselors around the United States, aims to be accepted within a field dominated by professionals who utilize what some counselors believe a biologically-based mode of treatment which in some fundamental ways directly opposes counseling models.

The results of this study also reveal a continuing trend (see Danzinger & Welfel, 2001) to manipulate diagnoses to fit reimbursement criteria by managed care companies in order to receive reimbursement for services. Therefore, if counselors want to be recognized as a legitimate provider of services by insurance companies, this practice must stop. A resolution must be sought so counselors in training do not leave their training programs lacking a sense of professional counseling identity which may lead to identifying themselves in terms meant for other professions (Hansen, 2003). Resolving this issue may be done by increasing training in diagnosis and the *DSM*, training on how to integrate the concepts of the *DSM* into the developmental paradigms of counseling. Resolving this issue may also be done by changing the role of counselors from that of an accepted diagnostician, to a strictly developmentally-oriented profession that does not seek to become a member of the healthcare industry.

Issues of bias in the *DSM* also speak to this ambiguous stance counseling seems to have when discussing diagnosis. It seems contradictory to validate the use of the *DSM* on the one hand (i.e. ACA) and then criticize it's inherent gender and cultural bias on the other (i.e., *ACA Code of Ethics*, 2005; Eriksen & Kress, 2005). Although the contributors of the *DSM-V* have acknowledged the need for more multiculturally and gender contexts be accounted for in all diagnoses, it may be useful for counselors to either strive to be a part of the discussion of the new *DSM*, or reject its use.

It is clear that current, practicing LPCs diagnose clients using the *DSM*. It is also clear that several ethical dilemmas arise for counselors who diagnose as well.

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**APPENDIX A**

**Other Licenses Held by Respondents**

## Other Licenses Held by Respondents

Licensed Substance Abuse Treatment Practitioner

Licensed Professional Clinical Counselor

Licensed Addictions Counselor

Licensed Clinical Social Worker

Licensed Rehabilitation Counselor

Licensed Chemical Dependency Counselor

Supervision Specialization

School Psychology Specialist

Psychological Examiner

Naturopath

Board Certified Pastoral Counselor

Certified Employee Assistance Professional

**APPENDIX B**

**Other Professional Organization Membership Responses**

## Other Professional Organization Membership Responses

Academy for Eating Disorders

American Art Therapy Association

American Association for Pastoral Counselors

American Association of Christian Counselors

American Association of Marriage and Family Therapists

American College Counseling Association

American College Personnel Association

American Educational Research Association

American Evaluation Association

American Music Therapy Association

American Occupational Therapy Association

American Psychological Association

American Psychotherapist Association

American Rehabilitation Counseling Association

American School Counselor Association

Arkansas Mental Health Counselors Association

Association for Assessment in Counseling and Education

Association for Conflict Resolution

Association for Counselor Education and Supervision

Association for Creativity in Counseling

Association for Humanistic Psychology

Association for Medical Education and Research in Substance Abuse

Association for Multicultural Counseling and Development

Association for Play Therapy

Association for Specialists in Group Work

Association for Spiritual, Ethical, and Religious Values in Counseling

Association for the Advancement of Psychosynthesis

Association for the Treatment of Sexual Abusers

Association for Transpersonal Psychology

Association for University and College Counseling Center Directors

Association of Adult Development and Aging

Association of Death Education and Counseling

Association of Family and Conciliation Courts

Association of Lesbian Gay Bisexual and Transgender Issues in Counseling

Chi Sigma Iota

Christian Association of Psychological Studies

Collaborative Law Institute of Texas

Counselors for Social Justice

DC Mental Health Counselors Association

Employee Assistance Professionals Association

Florida Association of School Psychologists

Florida Certification Board

Florida Mental Health Counselors Association

Florida School Counselor Association

Florida Society of Clinical Hypnosis

Georgia Association for Play Therapy

Georgia Christian Counselors Association

Georgia College Counseling Association

Georgia Regional Imago Therapists

International Association for Marriage and Family Therapists

International Association for the Study of Dreams

International Association of Addiction and Offender Counselors

International Association of Rehabilitation Professionals

International Society for the Study of Trauma and Dissociation

Kentucky Psychological Association

Licensed Professional Counselor Association of Georgia

Louisiana Career Development Association

Louisiana School Counselor Association

Mental Health Counselors Association of Palm Beach

National Association for Multicultural Education

National Association of Alcohol and Drug Abuse Counselors

National Association of Lesbian and Gay Addiction Professionals

National Association of School Psychologists

National Board of Certified Clinical Hypnotherapists

National Career Development Association

North American Association of Masters in Psychology

Northern Virginia Licensed Professional Counselors

Professional Academy of Custody Evaluators

Rio Grande Valley Counseling Association

Southern Association for Counselor Education and Supervision

State Division of American Association of Marriage and Family Therapists

Suncoast Mental Health Counselors

Tennessee Licensed Professional Counselors Association

Texas Association for Play Therapy

Texas College Counselors Association

Texas School Counselor Association

Virginia Association for Specialists in Group Work

Virginia Association of Clinical Counselors

Virginia School Counselors Association

William Glasser Institute

## **APPENDIX C**

### **Other Certifications Held by Respondents**



## Other Certifications Held by Respondents

Approved Clinical Supervisor

Board Certified Music Therapist

Board Certified Pastoral Counselor

Board Certified Professional Counselor

Certified Employee Assistance Professional

Certified Family Life Educator

Certification in Acute Traumatic Stress Management

Certified Addiction Counselor

Certified Addiction Professional

Certified Bereavement Facilitator

Certified Clinical Hypnotherapist

Certified Cognitive Behavioral Therapist

Certified Drug and Alcohol Counselor

Certified Employee Assistance Professional

Certified Forensic Addictions Examiner

Certified Forensic Mental Health Evaluator

Certified Gambling Counselor

Certified Group Psychotherapist

Certified Mediator

Certified Practitioner of Neuro-Linguistic Programming

Certified Rehabilitation Counselor

Certified Case Manager

Certified Substance Abuse Counselor

Certified Sex Therapist

Certified Sexual Addiction Therapist

Certified Sexual Offender Counselor

Certified Sports Counselor

Clinically Certified Forensic Counselor

Grief Recovery Specialist

Imago Relationship Therapist

Licensed Prevention Professional

Licensed Professional Counselor Supervisor Certification

National Academy for Certified Marriage and Family Therapists

National Certified School Psychologist

National Certified Psychologist

Reality Therapy Certified

Registered Mediator, State of Alabama

Registered Play Therapist

Registered Play Therapist Supervisor

School Counselor

Sex Offender Treatment Specialist

State Department of Mental Health Certification

Teacher Certification in Guidance and Counseling (K-12)

Texas Certified Counselor

Texas Certified School Counselor

## **APPENDIX D**

### **List of Self-Reported Practice Settings of Respondents**

## List of Self-Reported Practice Settings of Respondents

Adjunct University Instructor

Army

Behavioral Managed Care Company

Career Services

CEO/Clinical Director

Church

College

College Program Director

Community College Student Support

Contract Therapist

County Jail

Employee Assistance Program

First Responders

Government

Government Agency

Homeless Shelter

Hospital

Independent School

Jail Diversion Program for Co-Occurring Disorders

Managed Care

New Orleans Firefighters

Pro Bono Work

Residential Facility for Individuals with Intellectual Disabilities

Retired

School - Adult Education

School Psychologist

Supervise in Agencies

Trauma Crisis Counseling

U. S. Government Counseling Center

University

University Counseling Clinic

University Faculty and Staff Counseling Center (EAP)

**APPENDIX E**

**LPC Uses and Perceptions of the *DSM-IV-TR* (*UPDSM*)**

**LPC USES AND PERCEPTIONS OF THE *DIAGNOSTIC AND STATISTICAL MANUAL  
OF MENTAL DISORDERS-IV-TEXT REVISION (DSM-IV-TR)***

**SECTION I: PERSONAL INFORMATION**

**Please provide the following personal information:**

1. Gender:  
 Female  
 Male
  
2. Ethnicity:  
 African American  
 Asian American  
 Caucasian  
 Hispanic  
 Native American  
 Pacific Islander  
 Other \_\_\_\_\_
  
3. Highest level of education completed:  
 Master's                       Doctorate  
Year Graduated: \_\_\_\_\_ Year Graduated: \_\_\_\_\_
  
4. Years experience:  
 0-10     11-20     20-30     31-40     41+
  
5. Which of the following license(s) listed below do you **currently** hold and in what state (check all that apply)?  
 Licensed Professional Counselor (State: \_\_\_\_\_)  
 Licensed Marriage and Family Counselor (State: \_\_\_\_\_)  
 Licensed Mental Health Counselor (State: \_\_\_\_\_)  
 Other (please specify) \_\_\_\_\_ (State: \_\_\_\_\_)
  
6. Professional organizations of which you are a current member:  
 American Counseling Association  
 Corresponding State Branch of the ACA  
 ACA Division (please specify) \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_
  
7. Certifications Held (check all that apply):  
 National Certified Counselor  
 Certified Clinical Mental Health Counselor  
 National Certified School Counselor  
 Master Addictions Counselor  
 Not Applicable



\_\_\_\_\_ Other (please specify) \_\_\_\_\_

8. Current practice setting (check all that apply):  
\_\_\_\_\_ Private for-profit outpatient agency \_\_\_\_\_ Non-profit outpatient agency  
\_\_\_\_\_ School (K-12) \_\_\_\_\_ Private practice \_\_\_\_\_ College Counseling Center  
\_\_\_\_\_ Inpatient facility/Hospital \_\_\_\_\_ University Faculty
9. Age of client population with whom you work (check all that apply):  
\_\_\_\_\_ Children (0-12) \_\_\_\_\_ Adolescents (13-19) \_\_\_\_\_ Adults (20-50) \_\_\_\_\_ Adults (50+)  
\_\_\_\_\_ N/A
10. \_\_\_\_\_ Number of master's level university courses taken focusing on diagnosis and/or the *DSM*.
11. \_\_\_\_\_ Estimated continuing education hours completed focusing on diagnosis and/or using the *DSM* in practice.
12. I graduated from a CACREP (Council for the Accreditation of Counseling and Related Educational Programs) accredited counseling program. \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure

### SECTION II: DIAGNOSIS & USE OF THE *DSM-IV-TR*

1. Do you diagnose client mental disorders using the *DSM*? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. If you answered **no** for number 1 above, **why not**?  
\_\_\_\_\_ My job does not include/require diagnosing clients.  
\_\_\_\_\_ I do not believe that diagnosis is an appropriate practice in counseling.  
\_\_\_\_\_ My training did not adequately prepare me to utilize the *DSM*  
\_\_\_\_\_ It is unlawful in my state for LPCs to diagnose clients.  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_
3. If you answered **yes** to number 1 above, **or** if you have **past experience** diagnosing clients using the *DSM-IV-TR*, what would you list as your first and second **most important** reasons for using the *DSM-IV-TR*?  
**Please put the numbers 1 or 2 in the spaces provided.**  
\_\_\_\_\_ It is a necessary tool for the continuity of care with other mental health professionals for the clients I service.  
\_\_\_\_\_ It is a tool useful for practitioners to identify and treat mental health problems.  
\_\_\_\_\_ Diagnosis is necessary for insurance reimbursement.  
\_\_\_\_\_ It helps to dictate a plan of treatment for clients.  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_  
\_\_\_\_\_ Not applicable (**this answer will redirect participants to the message below**)

**Thank you for your participation in this survey, you have completed the section relevant to your experience.**

4. How often do you diagnose clients?

\_\_\_\_\_Consistently every week \_\_\_\_\_At least twice a month \_\_\_\_\_Less than twice a month

**SECTION III: PERCEPTIONS OF TRAINING, MULTICULTURAL ISSUES, & THEORETICAL ORIENTATION**

**Please indicate on a scale of 1 to 7 the extent to which you agree with the following statements. An answer of 1 indicates your strong disagreement with the statement and a 7 indicates your strong agreement with the statement. Please answer with a 4 if you are unsure about your agreement with the statement.**

1. I am a multiculturally competent practitioner.

<b>Strongly Disagree</b>						<b>Strongly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

2. The university graduate courses I completed adequately taught me the organization and structure of the *DSM* so I may understand and use it in practice.

<b>Strongly Disagree</b>						<b>Strongly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

3. My university instructors appeared to be in favor of diagnosis and using the *DSM* in my training program.

<b>Strongly Disagree</b>						<b>Strongly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

4. CACREP standards should increase emphasis on *DSM* and diagnosis training within counselor education programs.

<b>Strongly Disagree</b>						<b>Strongly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

5. Using the *DSM* in practice conflicts with my professional identity as a counselor.

<b>Strongly Disagree</b>						<b>Strongly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

6. The university graduate courses I completed adequately prepared me to recognize *DSM* mental disorders and diagnose them accurately.

<b>Strongly Disagree</b>						<b>Strongly Agree</b>
<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>

7. Courses I completed in diagnosis and the DSM included a discussion about multicultural issues when diagnosing clients.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
8. My licensing supervisor appeared to be in favor of diagnosis and using the *DSM*.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
9. The practicum/internship supervision I received from my university during my university graduate program appeared to be in favor of diagnosis and using the *DSM*.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
10. I attribute my decision to diagnose or not diagnose clients to my theoretical orientation.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
11. Courses I completed in counseling theories did not include discussion regarding diagnosis and the *DSM*.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
12. My licensing supervision appeared to be against diagnosis and using the *DSM*.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
13. When diagnosing clients, I practice from a multicultural perspective.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |
14. Courses I completed in multiculturalism included discussion regarding diagnosis and the *DSM*.
- |                          |          |          |          |          |          |  |                       |
|--------------------------|----------|----------|----------|----------|----------|--|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |  | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> |  | <b>7</b>              |

15. My university instructors appeared to be against diagnosis and using the *DSM* in my training program.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
16. The practicum/internship supervision I received from my university supervisor during my university graduate program appeared to be against diagnosis and using the *DSM*.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
17. I believe the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose culturally diverse clients accurately.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
18. Counselor education programs should increase the amount of required instruction regarding diagnosis and the *DSM*.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
19. The on-site supervision I received during my university practicum/internship graduate program appeared to be in favor of diagnosis and using the *DSM*.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
20. I believe the *DSM* does not adequately present disorders in such a way as to allow LPCs to diagnose women accurately.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
21. CACREP standards should de-emphasize DSM and diagnosis training within counselor education programs.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |
22. When diagnosing clients, I practice from a wellness oriented/developmental perspective.
- |                          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b>              |

23. The on-site supervision I received during my university practicum/internship graduate program appeared to be against diagnosis and using the *DSM*.
- |                          |          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>7</b>              |
24. Courses I completed in diagnosis and the *DSM* included a discussion about using the *DSM* within the context of counseling theories.
- |                          |          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>7</b>              |
25. I think counseling accreditation standards should require training in psychopharmacology.
- |                          |          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>7</b>              |
26. I believe LPCs should be Medicare and Medicaid providers despite requirements to provide client diagnoses.
- |                          |          |          |          |          |          |          |                       |
|--------------------------|----------|----------|----------|----------|----------|----------|-----------------------|
| <b>Strongly Disagree</b> |          |          |          |          |          |          | <b>Strongly Agree</b> |
| <b>1</b>                 | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>7</b>              |

#### SECTION IV: ETHICAL CONSIDERATIONS

- How often do you face any ethical dilemma(s) in regards to diagnosing clients?
  - More than once per week
  - Less than once per week
  - At least once a month
  - Less than once a month
  - Never
- Please briefly describe the most frequently occurring ethical dilemma you have encountered when diagnosing clients.

**APPENDIX F**

**IRB Letter of Approval**

**University Committee for the Protection  
of Human Subjects in Research  
University of New Orleans**

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*Campus Correspondence*

Principal Investigator: Louis V. Paradise  
Co-Investigator: Micah Patureau-Hatchett  
Date: January 25, 2007  
Protocol Title: "Counselors' Use and Perceptions of the DSM-IV-TR"  
IRB#: 22JAN08

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101(b) category 2 as a benign study of (anonymous) Counselors' perceptions of the DSM-IV-TR.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.

Sincerely,



Robert D. Laird, Ph.D., Chair  
Committee for the Protection of Human Subjects in Research

## **APPENDIX G**

### **Electronic Messages to Participants**



## First Electronic Message to Participants

Dear Licensed Professional Counselor:

I am a doctoral candidate under the direction of Professor Louis V. Paradise in the Department of Educational Leadership, Counseling and Foundations at the University of New Orleans. I developed the “LPC Uses and Perceptions of the *DSM-IV-TR*” (*UPDSM*) questionnaire in order to conduct a research study to measure the extent to which LPCs utilize the *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM-IV-TR)*. The *UPDSM* will also measure LPCs’ perceptions of their training, multicultural and ethical issues in regards to diagnosis and the *DSM-IV-TR*, and how their theoretical orientation impacts the process of diagnosis.

If you hold a professional counseling license, I request that you be a part of this study in order to contribute to the counseling body of knowledge about these issues facing professional counselors today.

If you choose to participate in this study, all information that you provide will be anonymous, and there will be no way of identifying you after you submit your answers. Although the results of the research study may be published or used in professional conference presentations, your name will not be used. The survey will take approximately 10-15 minutes to complete.

If you are willing to assist me with this important study, please click or cut and paste the following link in your browser to the *UPDSM*:

[survey link]

Completion and electronic submission of the *UPDSM* will indicate your consent to participate in this study. Again, your participation in this study is entirely voluntary, and if you choose not to participate or to withdraw from the study at any time, there will be no penalty to you.

The risks of participating in this study are minimal. You may tire while answering the questions or you may experience some discomfort due to the personal nature of some of the questions. If you would like additional information, have any questions concerning the research study, or you would like to discuss any discomfort you feel as a result of completing this study, you may contact me, Micah Patureau-Hatchett, by telephone, (504) 481-8195 or by email, mpaturea@uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by telephone, (504) 280-6026, or by email, louis.paradise@uno.edu.

Sincerely,

Micah Patureau-Hatchett, LPC, M.Ed., NCC  
Doctoral Candidate  
University of New Orleans  
348 Bicentennial Education Building  
University of New Orleans, Lakefront Campus  
New Orleans, LA 70148  
(504) 280-6026  
mpaturea@uno.edu

## Second Electronic Message to Participants

Dear Licensed Professional Counselors:

Approximately two weeks ago, I wrote to you in regards to a study I am conducting in order to measure the extent to which LPCs utilize the *Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM-IV-TR)*. The “LPCs Uses and Perceptions of the *DSM-IV-TR*” (*UPDSM*) is designed to also measure LPCs’ perceptions of their training, multicultural and ethical issues in regards to diagnosis and the *DSM-IV-TR*, and how their theoretical orientation impacts the process of diagnosis.

If you have already participated in this study by completing the *UPDSM*, I thank you.

If you have not had the opportunity to participate and are a licensed professional counselor, please take 10 minutes to read the following information and follow the hyperlink below to complete the *UPDSM*. Please note that current usage of the *DSM-IV-TR* is NOT required to complete this questionnaire.

I request that you be a part of this national study in order to contribute to the counseling body of knowledge about these issues facing professional counselors today.

If you chose to participate in this study, all information that you provide will be anonymous, and there will be no way of identifying you after you submit your answers. Although the results of the research study may be published or used in professional conference presentations, your name will not be used. The survey will take approximately 10-15 minutes to complete.

Clicking on or cutting and pasting the following link into your browser will allow you to access the *UPDSM*:

[survey link]

Completion and electronic submission of the *UPDSM* will indicate your consent to participate in this study. Again, your participation in this study is entirely voluntary, and if you choose not to participate or to withdraw from the study at any time, there will be no penalty to you.

The risks of participating in this study are minimal. You may tire while answering the questions or you may experience some discomfort due to the personal nature of some of the questions. If you would like additional information, have any questions concerning the research study, or you would like to discuss any discomfort you feel as a result of completing this study, you may contact me, Micah Patureau-Hatchett, by telephone, (504) 481-8195 or by email, mpaturea@uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by telephone, (504) 280-6026 or by email, louis.paradise@uno.edu.

Sincerely,

Micah Patureau-Hatchett, LPC, M.Ed., NCC  
Doctoral Candidate  
University of New Orleans  
348 Bicentennial Education Building  
University of New Orleans, Lakefront Campus  
New Orleans, LA 70148  
(504) 280-6026  
mpaturea@uno.edu

### Third Message to Participants

Dear Licensed Professional Counselors:

This is my last effort to encourage you if you have not had the opportunity to participate and are a licensed professional counselor, to please take 10 minutes to read the following information and follow the hyperlink below to complete the UPDSM. Please note that current usage of the DSM-IV-TR is NOT required to complete this questionnaire.

I am conducting a study to measure the extent to which LPCs utilize the Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM-IV-TR). The “LPCs Uses and Perceptions of the DSM-IV-TR” (UPDSM) is designed to also measure LPCs’ perceptions of their training, multicultural and ethical issues in regards to diagnosis and the DSM-IV-TR, and how their theoretical orientation impacts the process of diagnosis.

If you choose to participate in this study, all information that you provide will be anonymous, and there will be no way of identifying you after you submit your answers. Although the results of the research study may be published or used in professional conference presentations, your name will not be used. The survey will take approximately 10-15 minutes to complete.

Clicking on or cutting and pasting the following link into your browser will allow you to access the UPDSM:

[Survey Link]

Completion and electronic submission of the UPDSM will indicate your consent to participate in this study. Again, your participation in this study is entirely voluntary, and if you choose not to participate or to withdraw from the study at any time, there will be no penalty to you.

The risks of participating in this study are minimal. You may tire while answering the questions or you may experience some discomfort due to the personal nature of some of the questions. If

you would like additional information, have any questions concerning the research study, or you would like to discuss any discomfort you feel as a result of completing this study, you may contact me, Micah Patureau-Hatchett, by telephone, (504) 481-8195 or by email, mpaturea@uno.edu. You may also contact my faculty advisor, Dr. Louis V. Paradise, by telephone, (504) 280-6026 or by email, louis.paradise@uno.edu.

Sincerely,

Micah Patureau-Hatchett, LPC  
Doctoral Candidate  
University of New Orleans  
348 Bicentennial Education Building  
University of New Orleans, Lakefront Campus  
New Orleans, LA 70148  
(504) 280-6026  
mpaturea@uno.edu

## Final Message to Participants

Dear Participants:

Thank you to everyone who participated in my dissertation study survey titled “LPC Uses and Perceptions of the *DSM-IV-TR*.” The data collection and analyses has concluded.

If you would like to receive a copy of the final results, please send an email request to Micah Patureau-Hatchett at [mpaturea@uno.edu](mailto:mpaturea@uno.edu).

If you would like additional information about this study or if you would like to discuss any discomforts you may have experienced, please send your request to the principal investigator for this study, Micah Patureau-Hatchett, at [mpaturea@uno.edu](mailto:mpaturea@uno.edu). You may also contact my faculty advisor, Dr. Louis V. Paradise, by email, [louis.paradise@uno.edu](mailto:louis.paradise@uno.edu) or by telephone, 504-280-6026, for more information regarding this study.

Thank you again for your participation,

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## VITA

Micah Patureau-Hatchett earned a Bachelor of Arts degree in psychology from the University of New Orleans in 1998. Micah returned to the University of New Orleans and graduated with a Master of Education degree in mental health counseling in 2001, and a Ph.D. in counselor education from the University of New Orleans in August 2008.

Micah is a licensed professional counselor (LPC), and national certified counselor (NCC). She is a member of the American Counseling Association, and the Louisiana Counseling Association.

Micah has experience as a mental health counselor in a variety of settings, including a private partial hospitalization program, and a non-profit organization which provided psychoeducational groups to children of divorce. She served as a graduate assistant for the practicum and internship component in the Counseling Program of the University of New Orleans Department of Educational Leadership, Counseling, and Foundations, and was a university and group supervisor of master's students. She currently works in a private practice. She has participated in presentations about group process with the severely mentally ill, and helped to establish the Louisiana chapter of Counselors for Social Justice. She has co-authored some publications including one on multicultural issues and ethics in diagnosis.