DSM-5: A Commentary on Integrating Multicultural and Strength-Based Considerations into Counseling Training and Practice

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The 2013 publication of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5*) marked the reemergence of issues related to the appropriateness of diagnosis and the uses of the *DSM-5* within the counseling profession. Concerns focus on the implications of the *DSM-5* for counseling professionals whose professional identity is grounded in a prevention and wellness model, and the impact of the diagnostic process on counseling ethical practice. In this article, the authors explore the use of the *DSM-5* in counseling training and practice. The authors also discuss integrating *DSM-5* diagnosis into a counselor training framework while maintaining a wellness orientation. Multicultural and strength-based considerations are recommended when using the *DSM-5* in counseling training and practice, while maintaining consistency with a philosophical orientation focused on development and wellness and delivering services that are indicative of a unified counseling professional identity.

***Keywords*: diagnosis, *DSM-5*, strengths, wellness, counselor training, multicultural**

The history of the counseling profession dates back to the vocational guidance movement of the early 1900s. As society became increasingly industrialized, a need arose to improve individuals' vocational choices (Whiteley, 1984). With a focus on helping people to resolve problems in living, the counseling profession has maintained an emphasis on growth, prevention and early intervention across the life span (Gladding, 2013). Counseling is defined as "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Kaplan, Tarvydas, & Gladding, 2013). According to Remley and Herlihy (2014), many problems and issues that people face are developmental in nature. A wellness orientation toward helping and help seeking and the use of holistic approaches to treatment distinguish professional counselors from other mental health professionals (Mellin, Hunt, & Nichols, 2011). A focus on normal development and positive lifestyles promotes counselor professional identity and unifies the counseling profession (Gale & Austin, 2003). Given its common historical roots of assisting individuals with educational, occupational and emotional well-being (Whiteley, 1984), the field of counseling psychology also "maintains a focus on facilitating personal and interpersonal functioning across the life span. . . [with] particular attention to emotional, social, vocational, educational, health-related, developmental, and organizational concerns" (Society of Counseling Psychology, American Psychological Association, Division 17, 2014). Therefore, counselors, counseling psychologists and counselor educators benefit from understanding the dynamics of human growth and development in developing responsive interventions for clients with mental health concerns (Ibrahim, 1991). Furthermore, in creating a shared vision for supporting counselors, services to clients and the counseling profession, "advocat[ing] for optimal human development by promoting prevention

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and wellness" was among the six critical themes identified at the Counselor Advocacy Leadership Conference (Kaplan & Gladding, 2011, p. 368).

With the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM-5;* American Psychiatric Association [APA], 2013), issues related to counselor professional identity, diagnosis and the use of the *DSM-5* within the counseling profession have reemerged. Concerns focus on the implications of the *DSM-5* for counseling professionals who advocate prevention and wellness, and the impact of the diagnostic process on counseling ethical practice (Kress, Hoffman, Adamson, & Eriksen, 2013). Also, multicultural and contextual considerations may be ignored when adhering to a medical model implied by the *DSM* system. Despite these criticisms, few models exist for integrating diagnosis using the *DSM-5* into a wellness and prevention orientation, which is central to professional counseling training and practice. Our goal is to explore the use of the *DSM-5* in counseling training and practice, and to suggest ways that *DSM-5* diagnosis might be integrated into a counselor training framework while maintaining a wellness orientation.

DSM and Counseling Training

Distinguishing counseling from other mental health professions by a focus on human development, prevention and wellness does not exclude counseling professionals and trainees from acquiring an understanding of behavior across the adaptive-maladaptive continuum. In promoting a counselor professional identity, and reinforcing the consensus definition of professional counseling as empowering individuals, families and groups, teaching diagnosis using the *DSM-5* to counseling trainees requires a cultural and contextual understanding of individuals and their concerns. Providing counseling trainees with learning experiences designed to foster knowledge and skills extends beyond exposure to the *DSM-5* classification systems for categorizing behavior identified as disordered. Successfully integrating knowledge, skills and practices of diagnosis and the *DSM-5* into counselor education involves a review of counselor common core curricular and professional practice (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2009).

In the requirements for common core curricular experiences and demonstrated knowledge, CACREP (2009) requires that all counseling trainees learn about "the nature and needs of persons at all developmental levels and in multicultural contexts" (II.G.3, p. 10), including "theories for facilitating optimal development and wellness over the life span" (II.G.3.h, p. 10) and about "human behavior, including an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior" (II.G.3.f, p. 10). Furthermore, the standards for Addiction Counseling and Clinical Mental Health Counseling specifically require demonstrated "professional knowledge, skills, and practices" (CACREP, 2009, III, p. 17; p. 29), use of the current *DSM* and use of other diagnostic tools. Therefore, in addition to common core curricular experiences that develop knowledge and skills needed for "facilitating optimal development and wellness over the life span" (CACREP, 2009, II.G.3.h, p. 10), professional counselors must have diagnostic knowledge, skills and practices. This includes understanding "etiology, the diagnostic process and nomenclature, treatment, referral, and prevention of mental and emotional disorders" (CACREP, 2009, III.C.2, p. 30) and "the range of mental health service delivery" (III.C.5, p. 30). Specifically, CACREP (2009) standards require that counseling trainees must evidence knowledge, relevant skills and practices that include the following: knowledge of the use of the current edition of the *DSM* (i.e., *DSM-5*), an understanding of possible biases that might occur when using diagnostic tools with culturally diverse clients, knowledge of the correct use of diagnosis during a traumatic event, and the ability to differentiate "between diagnosis and developmentally appropriate reactions" to traumatic events (CACREP, 2009, III.L.3, p. 34). Moreover, in demonstrating knowledge, skills and practices of the diagnostic process, counseling trainees must understand the implications of diagnosis and treatment interventions. To this end, Kress et al. (2013) stressed the importance of weighing

both the benefits and risks of diagnosis when working with clients.

DSM-5 and Counseling Practice

Despite goals of revising the diagnostic classification scheme to make it "more clinically valuable and more biologically valid" (Nemeroff et al., 2013, p. 2), and of acknowledging cultural variations in clients' expressions of their concerns (Brown & Lewis-Fernández, 2011), the *DSM-5* has been criticized from within and beyond the psychiatric community. Released in May 2013, the *DSM-5* was met with controversy from mental health professionals and organizations representing their interest in providing effective clinical mental health services to clients (Washburn, 2013). Many viewed the *DSM-5* as an extension of the traditional medical model of diagnosis. For example, Ladd (2013) criticized *DSM* diagnosis for (1) ignoring the therapeutic alliance as a critical aspect of treatment; (2) depending on "statistically acquired symptoms" and "specific rules and timelines" created by Task Force/Work Group professional experts (p. 2); and (3) gearing its usefulness toward "insurance companies, managed care agencies and other professionals in the health care system" (p. 3). The American Mental Health Counselors Association (AMHCA) *DSM-5* Task Force (2012), among other groups, submitted feedback to improve the *DSM-5* draft. Although the *DSM* provides a common language for presenting client problems (Hinkle, 1999), the language and assumptions associated with the criteria for diagnosis became the focus of criticism. Stressing the important distinction of "separating the art of mental health diagnosis and complying with the mental health diagnosis business," Ladd (2013, p. 3) described the *DSM* as "the diagnostic instrument for the 'mental health diagnosis business' with categories and labels used as the language for insurance reimbursement, pharmaceutical treatment, and collaboration between experts" (p. 3).

Due to a growing need for quality mental health services, counseling professionals are providing services to clients presenting with a diverse range of concerns. Counselors are often required to diagnose clients' problems using the *DSM*-5 (Miller & Prosek, 2013). *DSM* diagnosis is necessary for counselors to access managed care and insurance company reimbursements (Hinkle, 1999). However, a traditional use of the *DSM* may pathologize behavior and separate diagnosis from treatment interventions (Ivey & Ivey, 1999). Counselors faced with these ethical dilemmas may question their professional identity, the usefulness of a wellness orientation and the effectiveness of counseling-related tasks (McAuliffe & Eriksen, 1999; Mellin et al., 2011). Counselors' challenge to adhere to a wellness orientation as the foundation of their professional identity may be further tested by other mental health professionals' tendency to conceptualize health and illness using models of pathology and remediation (McAuliffe & Eriksen, 1999). These dilemmas in counseling practice are more likely to become problematic when counselors are not grounded in a strong professional identity. Gale and Austin (2003) encouraged counselors to embrace a wellness model rather than an illness or deficit model of help seeking and treatment planning. Counselor clinical judgment is critical to the diagnostic process. Notwithstanding criticisms of the *DSM*, Johnson (2013) asserted that diagnosis is directly related to the philosophical and theoretical orientations of the clinician. The medical model used in diagnosis negatively impacts clients' willingness to seek help for their concerns, and also influences mental health professionals' orientations toward deficit models (McAuliffe & Eriksen, 1999).

Important considerations for teaching the *DSM* are directly related to understanding the diagnostic process and implications for models of helping used to conceptualize counseling goals and interventions with clients. Given the focus on prevention, wellness and health across the life span, key questions arise when teaching the *DSM-5* to counseling trainees from a traditional medical model that is "focused disproportionately on the physical aspects of illness" (Ingersoll, 2002, p. 115). A traditional disease model views the helper as the expert responsible for healing the client (McAuliffe & Eriksen, 1999). Brickman et al. (1982) viewed this model of helping as deficient in that the helper fosters dependency, which is antithetical to an empowering therapeutic relationship. Teaching the *DSM-5* to counseling students requires an understanding of a developmental and wellness orientation. Models of helping must be philosophically and theoretically congruent with a professional

counseling identity. To this end, counseling trainees must be challenged to examine their beliefs about seeking help and their view of a helper in the counseling relationship. Diagnosis and treatment should not be separate; rather, diagnosis should occur in conjunction with treatment (Ivey & Ivey, 1999). Viewing clients from a holistic perspective assumes that the greatest source of information lies within the client, not a manual or system of classifying disorders. Focusing on clients' strengths rather than deficiencies helps to empower clients as part of their learning and development. Integrating multicultural and strength-based considerations as part of the diagnostic process helps to ensure that clients receive culturally responsive counseling interventions.

Integrating Multicultural and Strength-Based Considerations

Counselors, counseling psychologists and counselor educators have been instrumental in recognizing the role of culture and integrating multicultural perspectives in an attempt to understand behavior more fully (Pedersen, 1991; Sue, Sue, Sue, & Sue, 2014). Although racial-ethnic minority groups remained underrepresented in research examining psychopathology, African-American and Hispanic or Latino clients are more likely to be diagnosed, to receive diagnoses of greater severity and to experience less effective treatment outcomes than are White clients (Johnson, 2013; Sue & Sue, 2013). Consequently, multicultural counselor competencies are necessary to address counselors' culturally biased assumptions and to increase counseling effectiveness in a society changing in culture and diversity (Arredondo et al., 1996; Pedersen, 1987, 2003; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982; Sue & Sue, 2013). Multiculturalism integrates culturally specific and universal perspectives in explaining the dynamics of behavior and developing culturally responsive approaches to treatment. However, counselors may ignore multicultural considerations when adhering to a medical model implied by the *DSM*. Ivey and Ivey (1999) called on counseling professionals to apply multicultural perspectives when using the *DSM*. In advancing a contextual understanding of behavior and disorders, Sue et al. (2014) developed a multipath model using four dimensions (i.e., biological, psychological, social and sociocultural) to describe etiological explanations of abnormal behavior.

Social, cultural and economic considerations must be acknowledged when attempting to identify and classify behavior diagnosed as maladaptive. Sue et al. (2014) distinguished cultural universality from cultural relativity in describing behavior within a sociocultural context. Important cultural nuances may be misunderstood when viewed by others who are culturally dissimilar. The result is the labeling of culturally normal behavior as maladaptive. To this end, myths associated with abnormal behavior have led to the social construction of diagnostic categories, which have been cited as major criticisms of using the *DSM*. Among these faulty assumptions is the belief that abnormal behavior can be readily recognized, distinguished from normal behavior and therefore categorized according to a diagnostic classification scheme (Maddux, 2002; Sue et al., 2014). Maddux (2002) further stated that diagnostic categories used in making biased clinical judgments lead to culturally unresponsive treatment interventions. Inherent in this approach is the basis of the medical model, in which clients are more often treated for pathological behavior (McAuliffe & Eriksen, 1999).

A step toward more holistic diagnostic practices appeared in the *DSM-5* in the form of dimensional rather than categorical assessments. These dimensional assessments of every categorical diagnosis were designed to assist counselors with diagnosis and treatment planning (Jones, 2012). Unlike previous versions of the *DSM* that used a categorical system, dimensional assessments view disorders on a continuum, representing varying degrees of a behavior (Sue et al., 2014). The dimensional assessment also allows counselors to consider individual differences and the influences of race and culture (Johnson, 2013). With the dimensional model, counselors are able to determine whether a diagnostic criterion is present and rate its severity (Brown & Lewis-Fernández, 2011). Viewing disorders on a continuum of behavior may decrease comorbidity; however, it also may affect clients' accessibility to services by eliminating clients who might have formerly met the criteria for diagnosis or diagnosing clients with a disorder that would have been excluded based on the former criteria.

Examples include autism spectrum disorder and depression resulting from bereavement, respectively. Given these changes, the effect of the *DSM-5* on diagnosis may impact clients' access to mental health services and create ethical dilemmas for counselors related to over- and undertreatment.

In addition to the dimensional assessments, the *DSM-5* also contains disorders associated with cultural issues. Psychosocial factors are included by using V codes from the World Health Organization's (WHO) *International Classification of Diseases, Ninth Revision, Clinical Modification* (*ICD-9-CM*; WHO, 1979) and Z codes from the *International Classification of Diseases, Tenth Revision* (*ICD-10*; WHO,1992), as well as three new terms: cultural syndrome, cultural idiom of distress and cultural explanation or perceived cause (Pomeroy & Anderson, 2013). Counselors must become familiar with the *ICD-10-CM* diagnostic codes, which will become the standard medical coding system in the United States beginning October 1, 2015. Inclusion of psychosocial factors evidences the relationship between psychosocial factors and mental health. Multicultural considerations in diagnosis allow mental health practitioners to understand cultural and individual characteristics that define identity and experience. These characteristics of a client's identity are multiple and interlocking. The uniqueness that defines a client may be lost if group generalizations as represented by the *DSM-5* are used as the only means of understanding a client's experiences. Critical to understanding clients and their stories is the ability to conceptualize clients as individuals interacting within the sociocultural context in which they live. This also involves hearing clients' stories from their perspective, using their own words.

The importance of cultural influences on mental health diagnosis also is demonstrated by the inclusion of the Cultural Formulation Interview (CFI; Pomeroy & Anderson, 2013). The CFI was developed to improve cross-cultural diagnostic assessment and was created from the Outline for Cultural Formulation (OCF) of the *DSM-IV* (Aggarwal, Nicasio, DeSilva, Boiler, & Lewis-Fernández, 2013). In keeping with multicultural competency models, the CFI provides a way for counselors to explore and understand clients' experiences and worldviews, as well as clients' cultural explanations and interpretations of their concerns. However, Aggarwal et al. (2013) cautioned that the overstandardization of the CFI may result in counselor and client barriers such as the following: a counselor misunderstanding the problem and the problem severity, a lack of conceptual relevance between the client's concern and counseling interventions, and a counselor and client's lack of acceptance and unwillingness to engage in the process. Counselors' ability to develop authentic and caring relationships is essential to accurate diagnosis and relevant counseling interventions. When clients are viewed as unique and counselors understand their experiences, accurate diagnosis and ethical practice are ensured (Swartz-Kulstad & Martin, 1999).

Moving beyond an illness model toward a counselor-client collaborative wellness model begins with a process of engaging with the client, gathering the information needed for assessing the client and trusting in the therapeutic alliance to accomplish the goals of treatment (Ivey & Ivey, 1999). Contrary to the medical or illness model, in which the client's weaknesses or deficiencies precipitate the diagnosis, treatment and policy decisions, the integration of a strength-based framework and counselor preparation ensures a holistic approach to assessment and treatment (Wright & Lopez, 2002). Working with clients from a holistic perspective requires knowledge and skills that preserve the integrity of the counseling profession by embracing multicultural and strength-based considerations. A framework adapted from positive psychology, defined as "the study of . . . what is 'right' about people—their positive attributes, psychological assets, and strengths" (Kobau et al., 2011, p. e1), assists in bolstering resilience and promoting mental health.

Strength-Based Approaches to Diagnosis

Character Strengths and Virtues

Character Strengths and Virtues: A Handbook and Classification (*CSV*; Peterson & Seligman, 2004),

which its authors dub a "Manual of the Sanities" (p. 3) in the introductory chapter, was developed in part as a companion to the *DSM* that focuses on classifying what is right about people. It includes explicit criteria for character strengths and launched the development of several assessment tools that aid in diagnosing one's strengths in the way that the *DSM* diagnoses one's limitations. Character strengths are the foundation of strength-based approaches and provide a way to assess client functioning from a wellness orientation (O'Hanlon & Bertolino, 2012). The *CSV* distinguishes three conceptual levels: (1) virtues: core characteristics that moral and religious philosophers esteem; (2) character strengths: processes that define virtues; and (3) situational themes: practices that lead people to establish specific character strengths in certain situations.

Parallel to the *DSM*, the *CSV* outlines 10 specific criteria that must be satisfied to warrant inclusion as a character strength. Using these criteria, 24 character strengths were identified under the respective umbrellas of six core virtues: (1) wisdom and knowledge (creativity, curiosity, open-mindedness, love of learning, and perspective); (2) courage (bravery, persistence, integrity, and vitality); (3) humanity (love, kindness, and social intelligence); (4) justice (citizenship, fairness, and leadership); (5) temperance (forgiveness and mercy, humility and modesty, prudence, and self-regulation); and (6) transcendence (appreciation of beauty and excellence, gratitude, hope, humor, and spirituality). The *CSV* also broadly outlines strength assessment strategies, as well as interventions that further cultivate strengths. For example, counselors might assist clients in realizing or reaffirming their virtue of strength of courage by exploring the will to achieve goals while facing external or internal opposition (O'Hanlon & Bertolino, 2012). This exercise empowers clients and provides counselors with a positive rather than a negative assessment of client behavior. Similarly, the use of positive talk moves clients away from a perspective of deficiency and illness toward encouragement and motivation for change.

Using the *CSV* in conjunction with the *DSM* enables counselors to help their clients identify, take pride in and use their character strengths and virtues to enhance well-being in all areas of their lives. Gander, Proyer, Ruch and Wyss (2013) found that using one's signature strengths in a different way lowered depression and boosted happiness for six months. Wood, Linley, Matlby, Kashdan and Hurling's (2011) longitudinal study determined that using one's strengths was correlated with well-being; decreased stress; and greater self-esteem, positive affect and vitality, with the effects still present at three-month and six-month follow-ups. Furthermore, the majority of positive counseling interventions focus on character strength interventions, which have been found to benefit both adults and children dealing with depression and anxiety (Rashid & Anjum, 2008; Seligman, Rashid, & Parks, 2006).

Client diagnosis and conceptualization using the *DSM-5* may be incomplete if clinicians do not consider clients' environmental resources, well-being and strengths (Snyder et al., 2003). Minor alterations to this diagnostic system could promote emphasis on positive functioning and provide information that could contribute to a more complete client picture and conceptualization. Recommendations for rescaling the Axis V Global Assessment of Functioning (GAF) Scale of the *DSM-IV-TR* included creating a functioning baseline, with the current GAF level of 100 (absence of symptomatology) rescaled to a midpoint of 50. This would have encouraged practitioners to identify and use client strengths, with a GAF of 1 representing severely impaired functioning, 50 representing good health and 100 representing optimal functioning. Snyder et al. (2003) also suggested adding personal strengths and growth facilitators through three brief questions and four positive psychology assessments that measure hope, optimism, personal growth initiative and subjective well-being. Similarly, Magyar-Moe (2009) suggested using a seven-axis system of positive psychological assessment that included documenting positive and negative aspects of clients' cultural identities, as well as clients' personal strengths as facilitators of growth.

These exercises, based in positive well-being, are consistent with a wellness orientation of helping and should not be solely limited to clients' growth and development. Counseling trainees and professional

counselors benefit personally and professionally when functioning from a strength-based orientation. For example, based on findings from attribution theory, negative labels affect motivation for change (O'Hanlon & Bertolino, 2012). Therefore, O'Hanlon and Bertolino cautioned against using negative diagnostic labels that may communicate a belief that clients are unable to change. From this perspective, counselors must continually examine their own behavior and the subtle messages that clients might receive during counseling. Through strength-based exercises, counselors are encouraged to promote strengths and resilience as part of an ongoing reflective practice.

Conclusion

Teaching the process of diagnosis using the *DSM-5* to counseling trainees is not an easy undertaking. Developed as a tool that promotes a language for use in the larger mental health system (Hinkle, 1999), the *DSM* is required learning for counseling trainees, and demonstrating professional knowledge, skills and practices is required for professional counselors. Teaching the basic vocabulary and criteria associated with disorders is only the first level of discussion. Effectively teaching diagnosis informed by multicultural and strength-based perspectives includes acknowledging the purpose and limitations of the *DSM-5*, and examining beliefs about helping, and the role and behavior of helpers. Counselors must explore the concept of normal behavior and their ability to identify abnormal behavior, as well as factors influencing growth and change.

Peterson (2013) stated, "we have developed a wonderful vocabulary that explains what goes wrong with folks and we have almost nothing to say about what can go right with folks" (p. 7). Teaching diagnosis and the *DSM-5* integrated with multicultural and strength-based considerations helps counselors to understand what goes right with clients. Through this understanding, clients' strengths, character and virtues become the support for growth and change within the counseling relationship. Rather than focusing on illness and deficiencies, counselors and clients acknowledge strengths and use them to assist clients in resolving problems in life. Informing the diagnostic process with multicultural and strength-based considerations fosters a holistic view of clients and reinforces counselor advocacy of optimal human functioning. Counselors must consider culture, context and strengths for the diagnostic process to be useful in working with clients from a wellness orientation (Adams & Quartiroli, 2010).

Furthermore, multicultural and strength-based practice considerations encourage reflection and counselor reflective practice, which challenge culturally biased assumptions that negatively affect counselor judgments about clients and the diagnostic process. As a result, counseling professionals do not view clients as confined and limited to a diagnosis; rather, they conceptualize clients as resilient and evolving (Adams & Quartiroli, 2010). Recognizing limitations and possibilities of the *DSM-5*, embracing a wellness and holistic orientation, and understanding clients from their cultural and situational contexts with a focus on strengths are critical factors that reduce ethical dilemmas and support the use of the *DSM-5* in counseling training and practice (Adams & Quartiroli, 2010; Gale & Austin, 2003; McAuliffe & Eriksen, 1999). Integrating multicultural and strength-based considerations into counseling training and practice increases the likelihood that counselors will embrace a professional identity congruent with a wellness orientation when using the *DSM-5* as a tool in the diagnostic process (Mannarino, Loughran, & Hamilton, 2007).

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