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DSM-5: Do Psychologists Really Want an Alternative?

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Abstract

Only two published studies, both from the early 1980s, have specifically examined psychologist attitudes toward the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). The current article rectifies this by presenting the results of a recent survey of attitudes toward the *DSM-IV-TR* and *DSM-5*. Though the *DSM* has changed over the years, psychologist attitudes toward it have remained remarkably consistent. Although more than 90% of psychologists report using the *DSM*, they are dissatisfied with numerous aspects of it and support developing alternatives to it—something that psychologists over 30 years ago supported, as well. The finding that almost all psychologists use the *DSM* despite serious concerns about it raises ethical issues because professionals are ethically bound to only use instruments in which they are scientifically confident.

Keywords

Diagnostic and Statistical Manual, psychologists, counselors, attitudes

The *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) dominates clinical practice. Its author, the American Psychiatric Association (2013), notes that

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> with successive editions over the past 60 years, it has become a standard reference for clinical practice . . . a tool for clinicians, an essential educational resource . . . and a reference for researchers in the field. (p. xli)

Oddly, there is no current research on psychologist attitudes toward and uses of the *DSM*, though past research suggests that most use it despite reservations. Using a measure one may not believe in for economic rather than clinical reasons raises ethical questions, but such questions are only justified if there are data supporting the contention that psychologists use the *DSM* despite serious concerns about it. The psychologist data on this issue are more than 30 years old. Thus, after reviewing the existing literature, we provide new survey data on this issue.

Opinions and Use of the DSM *System by Psychologists*

Miller, Bergstrom, Cross, and Grube (1981) studied psychologist attitudes toward the *DSM*, surveying 434 clinical and counseling psychologists about their opinions and use of it. Psychologists were clearly skeptical of the *DSM-II*. More than 40% felt it (a) distorted clinician perceptions of clients, (b) applied medical labels to psychosocial problems, (c) was not reliable and valid, (d) emphasized diagnosis over treatment, (e) obscured individual differences, and (f) overemphasized pathology. Almost 60% were dissatisfied or somewhat dissatisfied with the *DSM-II*, with only 17% satisfied or somewhat satisfied. Still psychologists consulted it roughly five times per month, despite rarely using it for case conceptualization. More than 85% used it to collect third-party payments, with 43% using it because it was the only system available.

Respondents were more inclined toward the *DSM-III*, but still ambivalent about this as-yet unseen version of the manual. Of those familiar with the proposed revisions, roughly 24% were satisfied or very satisfied, while 43% were dissatisfied or very dissatisfied. Nonetheless, 90% agreed that they would use the manual and almost half thought it would improve or somewhat improve diagnosis. While many respondents felt unable to comment on issues such as reliability, validity, the distinction between medical and mental disorders, and the multiaxial approach, those who did generally believed that the *DSM-III* needed improvement. While only 31% knew there was a Task Force on Descriptive Behavioral Classification charged with examining the merits of an alternative diagnostic system, 68% felt that the American Psychological Association should develop its own alternative manual—but only were willing to use it if third-party payers accepted it. Economic issues were understandably important to practicing psychologists. They were

reticent about the *DSM*, unsure about what its rise meant for them, and curious about alternatives (Miller et al., 1981).

DSM-III: *Do Psychologists Really Want an Alternative?*

Shortly after the *DSM-III*'s publication, Smith and Kraft (1983) presented another study of psychologist attitudes toward it. They surveyed 546 members of the American Psychological Association's Division 29 (Psychotherapy) about the *DSM-III* and found that psychologists (a) preferred social–interpersonal diagnosis, nondiagnosis, and behavioral analysis over *DSM-III*—in that order; (b) felt that most conditions in *DSM-III* were best seen as nonmedical problems in living; (c) believed too little had been done to develop scientific alternatives to the *DSM*; and (d) thought that client welfare and integrity would be better served by abandoning the medical model. Despite misgivings, respondents remained unsure whether psychologists risked losing autonomy if the *DSM-III* became the dominant approach used by insurers and the legal system. They were evenly divided on the issue of mental illness being considered a "myth" or due to "irresponsibility," although 85% disagreed that mental disorders are a subset of medical disorders. Those surveyed expressed many of the same concerns that the American Psychological Association was struggling with at the time. They seemed ambivalent about the *DSM-III* and interested in potential alternatives.

Other Professionals' Attitudes

Psychiatrists. Smith and Kraft (1989) also studied psychiatrist attitudes, finding psychiatrists more positive about the *DSM-III* than psychologists. In rank-ordering potential alternatives, psychiatrists differed from psychologists in preferring only one perspective—the biomedical model—to the *DSM-III*. Ranked below the *DSM-III* in order were behavioral diagnosis, social–interpersonal diagnosis, and no diagnosis. Other studies have confirmed the wide use and acceptance of the *DSM* by psychiatrists (Jampala, Zimmerman, Sierles, & Taylor, 1992; Junek, 1983; Kortan et al., 2000; Maser, Kaelber, & Weise, 1991; Setterberg et al., 1991; Someya, Takahashi, & Takahashi, 2001).

Social Workers and Counselors. Several studies have found that social workers see few advantages to the *DSM*, but increasingly use it and view it as important for third-party billing (Frazer, Westhuis, Daley, & Phillips, 2009; Kutchins & Kirk, 1988; Newman, Dannenfelser, & Clemmons, 2007; Probst, 2012). Half of social workers would not use it if not required (Frazer et al.,

2009) and many distinguish the *DSM* (which they associate with billing, insurance, and labeling) from "diagnosis" (which they see as a meaningful way to understand client behavior; Probst, 2012). Similarly, the minimal literature on counselor attitudes toward the *DSM* found that more than 90% of clinical mental health counselors identify the *DSM* as their most frequently cited resource (Mead, Hohenshil, & Singh, 1997). Counselors find *DSM* helpful for communication, with more than half saying they would use it even if doing so was not required for billing. Nonetheless, counselors see bias in labeling and under- or overdiagnosis as significant concerns; they also find the *DSM* problematic for use in couples and family counseling (Patureau-Hatchett, 2008; Strong, Gaete, Sametband, French, & Eeson, 2012). Still, 70% view the *DSM*'s advantages as outweighing its disadvantages (Mead et al., 1997; Patureau-Hatchett, 2008).

Why Study Psychologists' Attitudes Toward the DSM-5*?*

It is time to revisit psychologists' attitudes toward the *DSM* because of the (a) dearth of existing research and (b) renewal of professional interest due to the *DSM-5*. The *DSM-5* revision process was marked by debate and controversy. *DSM* supporters argued that the process was the most open, thorough, and scientific one yet conducted (American Psychiatric Association, 2011, 2012; Clarke et al., 2013; Narrow et al., 2013; Regier et al., 2013). However, critics offered a myriad of complaints, among them that the *DSM-5* lowers diagnostic thresholds, pathologizes normal human variations, adds scientifically suspect new disorders, and shifts in a biomedical direction at the expense of psychosocial conceptualizations (Frances, 2013; Greenberg, 2013; Pilgrim, 2014; Society for Humanistic Psychology, 2011, 2012). Concerns about the *DSM-5* became so widespread that the National Institute of Mental Health began discussing the eventual establishment of a biomarker-based alternative nosology grounded in its emerging Research Domain Criteria, in contrast to the *DSM*'s traditionally atheoretical behavioral diagnostic criteria (Sisti, Young, & Caplan, 2013). Thus, today's *DSM-5* faces much the same skepticism the *DSM-III* faced in the early 1980s when the last studies of psychologist attitudes toward it were undertaken.

Despite anecdotal suspicions of psychologists' dissatisfaction with the *DSM-5*, there is no current survey data on this issue. To remedy this, we examined psychologist attitudes toward the *DSM-IV-TR* and *DSM-5*. The survey posed many of the same questions asked by Smith and Kraft (1983) and Miller et al. (1981). Data were collected prior to the publication of the *DSM-5*—similar to Miller et al.'s (1981) seminal survey, which was done while a new *DSM* was in development and interest among professionals was high.

Method

Participants

One hundred twenty-eight anonymous psychologists participated. Data from the 104 participants who completed at least 75% of the nondemographic survey items and were licensed in or reported a primary professional identification in psychology were analyzed. Of these, 99 provided information regarding their primary professional identification. More than 95% of the psychologists primarily identified as clinical or counseling psychologists (66% and 27%, respectively). A summary of demographic data is provided in Table 1.

Materials

A 50-item online survey with structured fill-in response, forced choice, multiple response, and discrete visual analogue scale (DVAS) items was created to examine (a) current *DSM-IV-TR* usage patterns (3 items), (b) attitudes/beliefs about the *DSM-IV-TR* (3 items), (c) attitudes and beliefs about the *DSM-5* (6 items), (d) attitudes about the *DSM-IV-TR* versus the proposed *DSM-5* (13 items), (e) attitudes toward diagnosis and the development of a non-*DSM* diagnostic system (7 items), (f) general attitudes about diagnosis and the *DSM* (6 items), (g) demographic information (11 items), and (h) an optional final open-ended item for general comments. All DVAS items were displayed as 15 evenly spaced horizontally oriented radio buttons that were sequentially labeled from left to right with consecutive integers from 1 to 15 placed above each button, as well as verbal labels used as terminal anchors above the 5th and 11th radio buttons. For example, the following labeling scheme was used for several 15-point DVAS items: 1 (*much worse*), 5 (*worse*), 11 (*better*), 15 (*much better*). As such, scale labeling was symmetrical around the unlabeled scale midpoint (i.e., 8). Institutional review board (IRB) approval was secured for this internet survey research project.

Procedure

Participants voluntarily responded to recruitment announcements posted to the listservs of the Society for Clinical Psychology and the Society for Counseling Psychology by using a hyperlink in listserv announcements that directed participants to the survey, which was hosted and administered online using SurveyMonkey. Participants were informed that the purpose of the confidential and anonymous survey was to gather attitudes about diagnosis and the *DSM* and that voluntarily answering survey items constituted consent. Additionally,

Table 1. Summary Demographic Characteristics of Sample.

Variable	
Mean age (*SD*)	45.70 (15.40)
Number of respondents	98
Unknown/not answered	6
Gender	
Unknown/not answered	3
Women	62
Men	39
Ethnicity	
Unknown/not answered	5
Asian/Asian American	2
Black/African American	3
Caucasian/White	84
Hispanic/Latino	5
Native American	1
Other	4
Highest degree earned	
Unknown/not answered	5
BA/BS	3
MA/MS	15
EdD	0
PhD	68
PsyD	8
Other	5
APA accredited graduate?	
Unknown/not answered	6
No	18
Yes	80
Mean # years worked or involved in profession (*SD*)	18.07 (14.28)
Number of respondents	100
Unknown/not answered	4
Primary work activity	
Unknown/not answered	4
Administration	2
Applied practice	54
Consultation	3
Research	16
Supervision	0
Teaching	17
Other	8

(continued)

Table 1. (continued)

Variable	
Primary work setting	
Unknown/not answered	5
Academic department in college/university	32
Community mental health agency	6
Hospital	13
Private practice	22
University counseling/health center	13
Other	13
Primary theoretical orientation	
Unknown/not answered	3
Adlerian	0
Behavioral/cognitive–behavioral	42
Cognitive	3
Constructivist	0
Eclectic	15
Family systems	0
Gestalt	0
Humanistic/existential	7
Jungian	1
Object Relations/interpersonal	8
Psychoanalytic/psychodynamic	11
Reality therapy	0
REBT	0
Solution-focused	1
Transactional analysis	0
Other	13
Licenses held	
Unknown/not answered	17
Creative arts therapist	0
Marriage and family therapist	1
Professional counselor/mental health counselor	5
Psychologist	53
Social worker	2
None	21
Other	5

as per local IRB requirement, participants were explicitly informed that they were not required to complete all survey items and that they could stop at any time. Data were collected from May 14 to June 22, 2012.

Results

The analyses described below are organized based on the six main categories assessed by the survey (i.e., current *DSM-IV-TR* usage patterns; attitudes, and beliefs about the *DSM-IV-TR*; attitudes and beliefs about the *DSM-5*; attitudes about the *DSM-IV-TR* versus the proposed *DSM-5*; attitudes toward diagnosis and the development of a non-*DSM* diagnostic system; and general attitudes about diagnosis and the *DSM*). When items were not answered, the data point was excluded from the specific analysis. As a result, sample sizes vary across analyses and are reported for each analysis. Nondemographic data obtained from structured fill-in, forced choice, and multiple response items were treated as categorical-level measurement or frequency data and were analyzed using relevant nonparametric tests. Survey items that used a DVAS were treated as representing ordinal-level measurement and were also analyzed with nonparametric tests. Within each main category, family-wise Type I error was controlled using the Holm–Bonferroni correction (Holm, 1979).

Use of DSM-IV-TR

Monthly Use. Using two separate structured fill-in response format items, participants were asked to approximate the number of times per month they relied on the *DSM-IV-TR* manual directly (e.g., for classifying clients and/or communicating their diagnosis) and indirectly (e.g., to form hypotheses or conceptualize a client). Psychologists reported using the *DSM-IV-TR* indirectly almost 19 times per month ($M = 18.78$, $SD = 43.67$), while their direct use was significantly less at approximately 12 times per month ($M = 11.54$, $SD = 19.82$), $t(103) = 2.17$, $p = .032$.

Reasons for Use. Participants were asked, "Why do you use the *DSM-IV-TR*?" One multiple response item with 13 response options was provided and participants were instructed to select all that applied. Participants were also provided with an "other" option and were able to explain their reason. For the 104 psychologists, "to help make a differential diagnosis" (69.2%) and "to help conceptualize a case" (56.7%) were reported as the two primary uses of the *DSM-IV-TR*. Beyond these two reasons, from most to least frequently endorsed reasons, participants selected "required by third-party payers" (53.8%), "because it is the only classification system presently available" (42.3%), "I find it useful" (40.4%), "to help determine treatment" (34.6%), "required by employer" (27.9%), "to aid in research" (20.2%), "to help determine prognosis" (15.4%), "other" (14.4%), "because it is required by law"

(12.5%), "because psychiatrists use it" (12.5%), "because of its validity" (11.5%), and "because of its reliability" (11.5%).

Attitudes and Beliefs About DSM-IV-TR

General Satisfaction. Participants were asked, "Overall, what best describes your attitude toward *DSM-IV-TR*?" Participants responded using a single 15-point DVAS item anchored at 1 (*very unsatisfied*) and 15 (*very satisfied*). Results of a one-sample Wilcoxon signed-rank test revealed that the psychologists' attitude toward the *DSM-IV-TR* ($n = 104$, $Mdn = 7$) was significantly more negative than neutral (i.e., $Mdn = 8$), $z = -2.255$, $p = .024$.

Perceived Advantages. Participants were asked, "Which do you see as advantages of the *DSM-IV-TR*?" One multiple response item with nine response options was provided and participants were instructed to select all that applied. Participants were also provided with an "other" option and were able to explain their reason. From most to least frequently endorsed advantages, psychologists ($n = 104$) selected "multiaxial approach" (54.8%), "helps identify pathology" (51.9%), "diagnostic codes" (44.2%), "diagnostic classification often leads to most appropriate treatment" (30%), "has direct bearing on treatment" (22.1%), "atheoretical stance regarding etiology of disorders" (22.1%), "strong scientific basis" (21.2%), "other" (20.2%), "is reliable" (17.3%), and "is valid" (13.5%).

Perceived Disadvantages. Participants were asked, "Which do you see as disadvantages of the *DSM-IV-TR*?" One multiple response item with nine response options was provided and participants were instructed to select all that applied. Participants were also provided with an "other" option and were able to explain their reason. From most to least frequently endorsed disadvantages, psychologists ($n = 104$) selected "obscures individual differences" (60.58%), "places more emphasis on diagnosis than treatment" (51.92%), "places too much emphasis on pathology" (50.96%), "labels distort one's perception of a client" (43.27%), "applies medical labels to psychosocial problems" (43.27%), "has little bearing on treatment" (31.73%), "not reliable" (29.81%), "other" (22.12%), "not valid" (19.23%), and "diagnostic classification often leads to inappropriate treatment" (18.27%).

Attitudes and Beliefs About DSM-5

Familiarity With Proposed Changes. Participants were asked, "How familiar are you with proposed changes for the forthcoming *DSM-5*?" Participants

responded using a single 15-point DVAS item anchored at 1 (*very unfamiliar*) and 15 (*very familiar*). The results of a one-sample Wilcoxon signed-ranks test revealed that psychologists' familiarity with the proposed changes (n = 103, *Mdn* = 8) did not differ significantly from neutral, z = 0.257, p = .797.

Satisfaction With Proposed Changes. Participants were asked, "How satisfied are you with the changes being proposed for *DSM-5*?" Participants responded using a single 15-point DVAS item anchored at 1 (*very unsatisfied*) and 15 (*very satisfied*). Results of a one-sample Wilcoxon signed-rank test revealed that psychologists' satisfaction with the proposed *DSM-5* revision (n = 92, *Mdn* = 6) was significantly more negative than neutral, $z = -4.614$, $p < .001$.

Intention to Use DSM-5. Participants were asked "Do you expect to use *DSM-5* when it is published?" and responded using a yes/no forced choice. Despite the tendency toward dissatisfaction, 94.23% of the participants reported an intention to use the *DSM-5* on its publication.

Reasons for Use. Participants were asked, "Why do you expect to use the *DSM-5*?" One multiple response item with 13 response options was provided and participants were instructed to select all that applied. Participants were also provided with an "other" option and were able to explain their reason. For the 104 psychologists, "required by third-party payers" (50%), "for help with differential diagnosis" (44.23%), and "to help conceptualize a case" (42.31%) were reported as the three primary uses of the *DSM-5*. Beyond these three reasons, from most to least frequently endorsed reasons, psychologists selected "required by employer" (30.77%), "because it is the only classification system presently available" (25.96%), "to determine treatment" (23.08%), "to aid in research" (17.31%), "I find it useful" (13.46%), "to help arrive at a prognosis" (12.5%), "because psychiatrists use it" (11.54%), "because it is required by law" (10.58%), "other" (9.62%), "because of its validity" (6.73%), and "because of its reliability" (6.73%).

Effect on Diagnosis. Participants were asked, "In your professional opinion, what will be the most likely effect on diagnosis of implementing *DSM-5*?" Participants responded using a single 15-point DVAS item anchored at 1 (*significantly improve*) and 15 (*significantly hinder*). Results of a one-sample Wilcoxon signed-rank test revealed that the psychologists' prediction regarding the effect of *DSM-5* on diagnosis (n = 95, *Mdn* = 8) did not differ from neutral, $z = -1.051$, p = .293.

Effect on Clinicians. Dependent on subsample, participants were asked, "How do you think *DSM-5* will affect psychologists?" Participants responded using a single 15-point DVAS item anchored at 1 (*significantly harm*) and 15 (*significantly benefit*). Results of a one-sample Wilcoxon signed-rank test revealed that psychologists' prediction of potential harm or benefit that the *DSM-5* implementation would have on their profession ($n = 95$, $Mdn = 7$) did not significantly differ from neutral, $z = -1.943$, $p = .052$.

Comparing DSM-5 *to* DSM-IV-TR

Based on their familiarity with the proposed changes in the *DSM-5*, participants were instructed to compare the *DSM-5* to the *DSM-IV-TR* on 13 individual DVAS items, each using a 15-point scale anchored at 1 (*much worse*) and 15 (*much better*). Results of one-sample Wilcoxon signed-rank tests revealed that participants expected the *DSM-5* to be significantly worse than the *DSM-IV-TR* regarding "inappropriate classification of some behaviors as disorders," $p < .001$. Results for two items ("fair balance of biological, psychological, and social factors", $p = .006$, and "information on treatment", $p = .009$) suggested trends the *DSM-5* would be worse than the *DSM-IV-TR*. However, due to control for family-wise error, these results were not statistically significant. See Table 2 for results of analyses of all 13 items that compared the *DSM-5* to the *DSM-IV-TR*.

Attitudes and Beliefs Regarding Development of an Alternative Diagnostic System

Interest in Alternatives. Participants were asked, "Would you support seeing an alternative diagnostic system to the *DSM* developed?" Participants reported their degree of support using a single 15-point DVAS item anchored at 1 (*strongly support*) and 15 (*strongly oppose*). A one-sample Wilcoxon signed-rank test found that participants were supportive of the development of an alternative diagnostic system ($n = 100$, $Mdn = 5$, $z = -6.751$, $p < .001$).

Types of Alternatives Preferred. To examine the types of approaches participants would support in the development of an alternate, non-*DSM* diagnostic system, participants were instructed to rate their degree of support of six individual DVAS items, each using a 15-point scale anchored at 1 (*strongly support*) and 15 (*strongly oppose*). Rather than reporting neutrality (i.e., $Mdn = 8$), one-sample Wilcoxon signed-ranks tests revealed that participants

Table 2. Sample Sizes, Medians, and Results of One-Sample Wilcoxon Signed-Ranks Tests for Comparison of *DSM-5* to *DSM-IV-TR* and General Attitudes About Diagnosis and *DSM*.

Variable	*n*	*Mdn*	*z*	*p*
Comparison of *DSM-5* to *DSM-IV-TR*				
Inappropriate classification as disorders	82	7	−4.865	<.001
Fair balance	79	8	−2.748	.006
Information on treatment	78	8	−2.612	.009
Reliability	80	8	−2.296	.022
Validity	80	8	−2.024	.043
Multiaxial approach	78	8	0.689	.491
Definitions of mental disorders	79	8	−0.934	.35
Reflection of current scientific knowledge	81	8	0.038	.969
Information supported by empirical data	81	8	−0.947	.343
Information on prognosis				
Communication between professionals	79	8	−1.362	.173
Information on differential diagnosis	79	8	−1.579	.114
Clear and scientific operational definitions	79	8	−0.093	.926
General attitudes about diagnosis and *DSM*				
Promotion of scientific alternatives	99	11	5.916	<.001
Reliance on medical semantics	100	9	2.939	.003
Relation between medical and mental disorders	99	5	−5.575	<.001
Nonmedical problems	102	7	−1.986	.047
Client welfare	101	8	0.073	.942
Psychologists have lost their autonomy	101	8	0.240	.810

supported the development and use of "social-interpersonal diagnosis" (n = 95, Mdn = 5, z = −7.382, p < .001), "mapping developmental and personal meanings" (n = 93, Mdn = 5, z = −5.575, p < .001), "behavioral analysis" (n = 96, Mdn = 5, z = −6.067, p < .001), and "assessment of faulty beliefs/cognitions" (n = 95, Mdn = 5, z = −6.151, p < .001). The preference for the development and use of "nondiagnosis" as an alternative was also assessed, but participants' preference for this did not differ from neutral (n = 87, Mdn = 8, z = −0.133, p = .894). The final item used to examine the types of approaches participants would support in the development of an alternate, non-*DSM* diagnostic system was "none of the above, prefer the *DSM* instead." In hindsight, we judged this item as poorly worded and, because it was double-barreled, determined that the findings could not be clearly interpreted. Nevertheless, participant responses to this item did not differ from neutral (n = 61, Mdn = 9, z = 1.851, p = .064).

General Attitudes About Diagnosis and the DSM

To examine participant beliefs and attitudes regarding diagnosis and the influence of the *DSM*, participants were instructed to rate their level of agreement to six individual DVAS items each using a 15-point scale anchored at 1 (*strongly disagree*) and 15 (*strongly agree*). Results of one-sample Wilcoxon signed-rank tests revealed that participants agreed that "too little has been done to promote a scientific alternative to the *DSM*," $n = 99$, $Mdn = 11$, $z = 5.916$, $p < .001$, and that the "DSM relies too heavily on medical semantics," $n = 100$, $Mdn = 9$, $z = 2.939$, $p = .003$. Participants disagreed that "mental disorders are a subset of medical disorders," $n = 99$, $Mdn = 5$, $z = -5.575$, $p < .001$. There was a trend toward disagreement that "most conditions that *DSM* labels as mental disorders can best be described as non-medical problems in living," $n = 102$, $Mdn = 7$, $z = -1.986$, $p = .047$. However, due to family-wise error correction, this finding was not statistically significant. Participant attitudes did not differ from neutral on the remaining two items (i.e., "client's welfare would be better served by abandoning the medical model in training and practice," $n = 101$, $Mdn = 8$, $z = 0.073$, $p = .942$; and "psychologists have lost their autonomy because of the widespread influence of the *DSM*," $n = 101$, $Mdn = 8$, $z = 0.240$, $p = .810$.

Discussion

General Attitudes Toward the DSM

Used Despite Dissatisfaction. Psychologists not only viewed the *DSM-IV-TR* more negatively than neutral, but also were dissatisfied with the proposed *DSM-5* and thought it would inappropriately classify more behaviors as disorders than *DSM-IV-TR*. Nevertheless, 90% of psychologists surveyed regularly used the *DSM-IV-TR* and 94% planned to use the *DSM-5*. The results are no different from what was found three decades ago, namely, that a significant number of psychologists are unhappy with the *DSM*, but almost all of them use it.

Advantages and Disadvantages. Psychologists saw some of the same things as advantages and disadvantages of the *DSM-IV-TR*. Its ability to identify pathology and provide diagnostic codes were rated highly as advantages, which makes sense considering that the manual is widely used by practitioners to assign diagnoses and codes integral to third-party payments. The multiaxial approach was also seen as an advantage of the *DSM-IV-TR*, which is interesting given that this approach has been eliminated from the *DSM-5*. Regarding disadvantages, psychologists felt the *DSM-IV-TR* obscures individual differences, is too focused on diagnosis compared with treatment,

overemphasizes pathology, distorts perceptions of clients, and medicalizes psychosocial problems. These results are consistent with attitudes that psychologists expressed over 30 years ago (Miller et al., 1981; Smith & Kraft, 1983). Successive revisions have not changed what psychologists see as the *DSM*'s advantages and disadvantages.

Attrition. It is worth noting that when it came to items comparing the *DSM-IV-TR* to the *DSM-5*, many respondents did not answer. Roughly 25% of the psychologists surveyed did not complete the items asking them to compare *DSM-IV-TR* and *DSM-5*. We do not know why these items were left out, nor are we clear about whether those who failed to answer these items differed from those who did. It is possible that the high attrition rates for these items influenced the results. Response rates to the rest of the survey were consistently high.

Development of Alternatives to the DSM

Support for Alternatives. In the 1980s, psychologists supported alternatives to the *DSM* (Miller et al., 1981; Smith & Kraft, 1983). Despite the *DSM*'s long reign and continued supremacy in research and practice settings, the desire for alternatives remains. Psychologists surveyed strongly supported the development of alternatives to the *DSM-5*.

Alternatives Preferred. Psychologists in the early 1980s supported developing social–interpersonal and behavior analysis alternative diagnostic systems; they also supported nondiagnosis. Thirty years on, psychologists still support developing social–interpersonal and behavior analysis alternatives, while also supporting two alternatives not asked about 30 years ago: mapping developmental and personal meanings and assessing faulty beliefs and cognitions. While 30 years ago psychologists supported nondiagnosis, nowadays they do not favor giving up diagnosis. It is the *DSM* specifically rather than diagnosis broadly about which they have mixed feelings. More confident today in the importance of diagnosis, psychologists remain interested in alternatives. While the American Psychological Association has intimated that the World Health Organization's *International Classification of Diseases* (*ICD*) might be a preferred alternative to the *DSM* (ICD vs. DSM, 2009), our results suggest that even though they may not see the categories in the *DSM* as merely problems in living, psychologists are interested in alternatives not rooted in the medical model common to the *DSM* and *ICD*. Psychologists might be prepared to further develop and use psychologically focused diagnostic alternatives if conditions encouraging them to do so were in place.

Four Issues. Smith and Kraft (1983) believed that the *DSM-III* presented psychologists with issues pertaining to science and methodology, professional purview, economics, and ethics. These issues remain relevant to the *DSM-5*. Interestingly, during the *DSM-5* revision process the American Psychological Association (2011) called for the *DSM-5* Task Force to rely on science to inform revisions. In terms of professional purview, there appears to be less talk among psychologists now than in the early 1980s about whether the *DSM* will endanger their professional status (Smith & Kraft, 1983), but how comfortable psychologists are with the push toward a more psychophysiological conception of mental disorder remains an open question. As for economic concerns, the American Psychological Association is sponsoring a variety of continuing education sessions on the *DSM-5*; this ensures psychologists are knowledgeable about the manual and can continue using it for insurance billing, but also serves to further inculcate a diagnostic system about which psychologists have serious concerns. Finally, ethical concerns remain, with the question being whether it is appropriate for psychologists who have concerns about the scientific status of the *DSM* to continue using it. Professional ethics forbids the use of instruments one does not believe to be valid, yet the results of the current survey suggest that most psychologists are using the *DSM* as a means to collect insurance payments despite serious reservations about it.

Conclusion

DSM-5 is relatively new, so future research might look at whether the attitudes of psychologists toward it change after it has been in use for a while. Future studies might also look at specific changes to particular disorders that psychologists do or do not like. Still, the present study provides clear evidence that psychologists have mixed feelings about the *DSM* in general and look at it with considerable skepticism. Most strikingly, psychologists' attitudes toward the *DSM* have not changed much in three decades. They appreciate its help in making diagnoses and supplying reimbursable diagnostic codes, but continue to have scientific, professional, economic, and ethical concerns about it. Nonetheless, the vast majority of psychologists use the *DSM* despite serious misgivings about it. Psychologists no longer entertain giving up diagnosis entirely, but remain dissatisfied with aspects of the *DSM* system and support developing alternatives. The *DSM* may have changed over the years, but psychologists' attitudes toward it remain remarkably similar. Should a viable alternative to it be put forward and made economically practical, psychologists just might adopt it.

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