Psychologist Attitudes Toward DSM-5 and Its Alternatives

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The authors have no known conflicts of interest. The survey is included as supplementary online material, and the data collected is available upon request. The study was not preregistered. Address correspondence to Dr. Jonathan D. Raskin, Department of Psychology, Wooster Hall, 1 Hawk Dr., New Paltz, NY 12561. E-mail: raskinj@newpaltz.edu.

Abstract

A survey of psychologists' attitudes toward the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) and its alternatives was conducted. Almost 90% of psychologists reported regularly consulting DSM-5, despite dissatisfaction with it. However, opinions varied by theoretical orientation. Cognitive-behavioral psychologists held positive attitudes about DSM, whereas psychodynamic and humanistic/constructivist/systems psychologists were negatively inclined toward it. Integrative/eclectic psychologists were in between. Diagnostic codes and identifying pathology were seen as DSM-5's biggest advantages, and the medicalization of psychosocial problems and obscuring individual differences as its biggest disadvantages. Psychologists supported developing alternatives to DSM-5, but when asked about six alternatives—*International Classification of Diseases* (ICD), Research Domain Criteria (RDoC), *Psychodynamic Diagnostic Manual 2* (PDM), *Operationalized Psychodynamic Diagnosis* (OPD), Hierarchical Taxonomy of Psychopathology (HiTOP), and Power Threat Meaning Framework (PTMF)—they were generally unfamiliar with them except for ICD. Although not wishing to abandon the medical model, psychologists (except for cognitive-behaviorists) said DSM-5 relies too much on medical semantics and questioned whether mental disorders should be considered a subset of medical disorders. Overall, psychologists use DSM for practical reasons (diagnostic categories and codes) more than scientific ones (validity and reliability). This finding affirms something remarkable: Despite ongoing attention to revising and improving DSM over the past four decades, psychologists remain lukewarm toward it and strongly interested in alternatives. However, until alternatives are better known and provide the necessary practical advantages, psychologists will likely continue to use DSM despite their mixed feelings about it.

Public Significance Statement

This study found that nearly 90% of psychologists use DSM despite dissatisfaction with it. Psychologists see DSM's main advantage as third-party insurance reimbursement. Though they wish to see

alternatives developed, they are unfamiliar with and unsupportive of any besides the *International Classification of Diseases* (ICD). Psychologists want alternatives but have a practical need to get paid that DSM currently meets.

Psychologist Attitudes Toward DSM-5 and Its Alternatives

The American Psychiatric Association's (APA, 2013) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is the world's seminal diagnostic system for mental health issues. The DSM-5, published in 2013 and recently reissued with some minor tweaks as DSM-5-TR (APA, 2022), is familiar to most psychologists. However, what they currently think of the manual remains unclear. The small body of existing research suggests they are lukewarm toward it. Suspecting that many U.S. psychologists view the manual with suspicion and use it mostly to secure third-party payments, we undertook a survey exploring psychologist attitudes toward DSM and several alternatives to it.

Psychologist Attitudes Toward the DSM

Research on psychologist attitudes toward DSM is scarce. To examine it, we conducted a systematic review without meta-analysis, which was justified because the body of literature is small (Johnson, 2021). During the early 1980s, shortly after DSM-III appeared (APA, 1980), two studies on attitudes about it were published. The first found that 90.6% of respondents were using DSM-II (APA, 1968) but more than 40% worried it distorted how clinicians perceive clients, medicalized psychosocial problems, had reliability and validity issues, stressed diagnosis at the expense of treatment, obscured individual differences, and over-pathologized people (Miller et al., 1981). Of those surveyed, 58.5% were dissatisfied or somewhat dissatisfied with DSM-II and 24.5% were ambivalent. Only 17% were satisfied or somewhat satisfied. Attitudes toward the then-forthcoming DSM-III were only marginally more positive: 43.4% were dissatisfied or somewhat dissatisfied, 32.4% were ambivalent, and 24.1% were satisfied or somewhat satisfied. Nonetheless, 90.2% of respondents planned to use DSM-III even though only 19.1% thought it would benefit psychology. When asked about developing an alternative to DSM, 68.1% were supportive—if third-party payers would accept it. Miller et al. (1981) concluded that "despite the criticisms made of the DSM system . . . the overwhelming majority of practicing psychologists continue to use it" (p. 389).

The second early 1980s study asked 546 psychologists from the American Psychological Association's Division 29 (Psychotherapy) about DSM-III and several alternatives to it (Smith & Kraft, 1983). DSM-III was rated lowest, with only 13% of respondents across all theoretical orientations ranking it the most desirable approach. Further, 79% believed that "too little had been done to promote a scientific alternative to DSM-III" (Smith & Kraft, 1983, p. 782). Respondents felt most DSM-III diagnoses were better viewed as problems in living, that too little had been done to develop alternatives, and that shifting from the medical model would benefit clients. In fact, 85% disagreed that mental disorders are a subset of medical disorders. The Miller et al. (1981) and Smith and Kraft (1983) surveys suggest that early 1980s psychologists were dissatisfied with DSM and open to alternatives.

Since these two studies, there has been little research specifically on psychologist attitudes toward DSM. A 2016 World Health Organization global survey looked at attitudes about diagnostic classifications more broadly, finding psychologists value them to inform treatment and facilitate communication but prefer flexible diagnostic guidelines over strict criteria and worry about culture bias (Evans et al., 2016). Research on other professions shows, not surprisingly, that psychiatrists generally hold a positive view of DSM (Jampala et al., 1992; Junek, 1983; Kortan et al., 2000; Maser et al., 1991; Setterberg et al., 1991; Someya et al., 2001), while social workers and counselors use it and appreciate its scientific and practical benefits but are concerned about potential bias, stigmatization, medicalization, and over-pathologizing (Gayle & Raskin, 2017; Frazer et al., 2009; Hitchens & Becker, 2014; Nelson, 2019; Newman et al., 2007; Probst, 2012; Strong et al., 2012).

In 2016, we published the first new research on psychologist attitudes toward DSM in many years (Raskin & Gayle, 2016). Our results were comparable to Miller et al. (1981) and Smith and Kraft (1983), with respondents expressing a more negative than neutral view of DSM-IV-TR (APA, 2000) and DSM-5. Despite their misgivings, 94.23% of the psychologists planned to use DSM-5. The top reasons were third-party payments, help with differential diagnosis, and case conceptualization. Though they

planned to use it, psychologists were neutral about whether DSM-5 benefitted psychology as a profession. Further, psychologists expressed support for alternatives, agreeing that "too little has been done to promote a scientific alternative to the DSM" and the "DSM relies too heavily on medical semantics." Our study indicated psychologist attitudes about DSM have remained largely consistent since the 1980s; they no longer support discarding diagnosis entirely but remain skeptical of DSM and are open to alternatives.

Alternatives to DSM

Information on alternatives is starting to be disseminated to clinicians (Phillips & Raskin, 2021). The most publicized alternative is the mental disorders section of the *International Classification of Diseases* (ICD) (World Health Organization, 1992, 2022). With its categorical approach to diagnosis and harmonization with DSM, it is clearly the most similar to it. Some might even see it as not fundamentally different from DSM. Nonetheless, the American Psychological Association has published a primer on ICD to educate psychologists about it (Goodheart, 2014).

The *Psychodynamic Diagnostic Manual 2* (PDM) is a diagnostic system grounded in psychodynamic theory (Lingiardi & McWilliams, 2017). Rather than remaining descriptive and atheoretical, it reframes mental disorders in explictly psychodynamic terms. A second edition, PDM-2, has been developed. Similarly, *Operationalized Psychodynamic Diagnosis* (OPD) is another diagnostic system rooted in psychodynamic theory (OPD Task Force, 2008).

The Hierarchical Taxonomy of Psychopathology (HiTOP) offers a non-categorical diagnostic approach, seeking to replace DSM's hundreds of categories with six scientifically-derived spectra dimensions (Conway et al., 2022; Kotov et al., 2021). HiTOP aims to overcome DSM's comorbidity issues by offering a simpler diagnostic approach grounded in empirical assessment data. The Research Domain Criteria (RDoC) is another diagnostic initiative heavily rooted in research. Undertaken by the National Institute of Mental Health (NIMH), RDoC is an effort to develop a biomarker based diagnostic system

(Akram & Giordano, 2017; Cuthbert, 2014). At this time, it remains a research initiative and is not yet a useable nomenclature.

Finally, the Power Threat Meaning Framework (PTMF) is the most radical alternative to DSM. It rejects diagnosis for incorrectly locating problems in people rather than their social surroundings. PTMF replaces diagnostic labels with collaborative formulations identifying *power* (what happened), *threat* (how it was experienced), and *meaning* (the sense made of it) (Johnstone et al., 2018).

How Do Psychologists Feel About DSM?

To see if psychologist attitudes have changed since DSM-5 appeared, we conducted a new survey replicating many aspects of our prior research. The current survey diverged from our earlier ones in two important ways: (a) it asked about attitudes toward DSM-5 instead of DSM-IV-TR (DSM-5 was in development then, so questions about it were anticipatory only); and (b) it asked about specific diagnostic alternatives rather than general theoretical preferences for alternatives (specific alternatives were at too early a stage of development to ask about then). In the present study, we wished to know if psychologists use DSM-5 as regularly as previous DSMs. We also wanted to know if they still attribute the same advantages and disadvantages to DSM-5 that they did to earlier versions of the manual. We predicted:

- Given negative views of DSM in previous studies, psychologists would be more unsatisfied than satisfied with it, even while viewing DSM-5 as somewhat improving diagnosis.
- Consistent with past findings, psychologists would be neutral on whether DSM-5 has helped or hurt their profession but would generally support alternatives gaining influence.
- Despite predicting mixed to negative impressions of DSM-5, we expected over 90% of respondents to use the manual. Two of the most popular reasons would be differential diagnosis and third-party billing.

How Do Psychologists Feel About Alternatives to DSM-5?

When it comes to alternatives to DSM-5, we hypothesized:

- Psychologists would be familiar with ICD because DSM is harmonized with it and the American Psychological Association has published a primer to educate clinicians about it (Goodheart, 2014).
- Psychologists would be unfamiliar with the alternatives discussed above, except for ICD.
- Psychologists would not express support for development or use of any alternative to DSM other than ICD. We predicted this because we expected psychologists to be unfamiliar with most alternatives.
- Psychologists would prefer the continued development and use of DSM over its alternatives; this was a "devil you know" hypothesis prefaced on the assumption that psychologists would be reluctant to support alternatives with which they were unfamiliar.

What Are Psychologists General Attitudes About Diagnosis?

Several additional predictions were made about psychologist attitudes toward diagnosis:

- As in our 2016 study, psychologists would agree that "DSM relies too heavily on medical semantics" and "too little has been done to promote a scientific alternative to the DSM," while disagreeing that "mental disorders are a subset of medical disorders."
- Again, as in our 2016 study, psychologists would be neutral regarding whether "psychologists have lost their autonomy because of the widespread influence of the DSM," "clients' welfare would be better served by abandoning the medical model in training and practice," and "most conditions that DSM labels as mental disorders can best be described as non-medical problems in living."

- Psychodynamically and humanistically-oriented therapists would be dissatisfied with DSM while cognitive-behavioral and integrative/eclectic therapists would be neutral toward or supportive of it.
- Psychodynamically and humanistically-oriented therapists would agree with several statements that cognitive-behavioral and integrative/eclectic therapists would be neutral toward or disagree with: "Mental disorders are a subset of medical disorders," "DSM relies too heavily on medical semantics," "clients' welfare would be better served by abandoning the medical model in training and practice," and "most conditions that DSM labels as mental disorders can best be described as nonmedical problems in living."
- Psychologists across all orientations would agree that "too little has been done to promote a scientific alternative to the DSM."

Method

Survey Instrument

The study, which received Institutional Review Board (IRB) approval from the State University of New York at New Paltz, used a 49-item Qualtrics online survey containing fill-in response, forced choice, multiple response, and visual analogue scale (VAS) items (the full survey is available as supplemental material online). Items asked respondents (a) how many times per month they directly and indirectly use DSM-5, (b) why they use DSM-5, (c) what they see as DSM-5's advantages and disadvantages, (d) how satisfied they are with DSM-5, (e) their view of DSM-5's impact on diagnosis generally and psychologists specifically, (f) whether they wish to see alternatives to DSM-5 developed, (g) how familiar they are with alternatives to DSM-5, (h) their degree of support for developing and using various alternatives to DSM-5, and (i) their general attitudes about diagnosis and DSM. The survey also collected demographic information and permitted open-ended comments.

Each VAS item appeared as a 15-point scale with a slider bar underneath it. The 15-point scales above each slider bar contained consecutive integers numbered from 1 to 15. Four terminal anchor verbal labels were placed evenly along the scale above the numbers 1-2, 5-6, 10-11, and 14-15. The specific verbal labels used varied by item. As one example, the item asking about overall attitude toward DSM-5 contained the following labels: 1-2 (*very unsatisfied*), 5-6 (*unsatisfied*), 10-11 (*satisfied*), 14-15 (*very satisfied*). These labels were symmetrical around an unlabeled scale midpoint of 8. When completing the survey online, respondents could click anywhere on the bar below each scale and then drag the slider backward or forward to a desired location. Thus, respondents were not restricted to simply selecting one of the 15 integers; their responses were continuous along the slider bar.

Participants, Recruitment, and Procedure

An email invitation with instructions and a link to the survey was sent to 9,625 psychologists on the membership lists of the following American Psychological Association Divisions: 12 (Clinical Psychology), 16 (School Psychology), 17 (Counseling Psychology), 22 (Rehabilitation Psychology), 25 (Behavior Analysis), 28 (Psychopharmacology and Substance Abuse), 29 (Psychotherapy), 30 (Psychological Hypnosis), 32 (Humanistic Psychology), 39 (Psychoanalysis and Psychoanalytic Psychology), 42 (Independent Practice), 49 (Group Psychology and Group Psychotherapy), 53 (Clinical Child and Adolescent Psychology), 55 (Advancement of Pharmacotherapy), and 56 (Trauma Psychology). These divisions were selected because of their focus on clinical practice; members of these divisions are likely to have had experience with DSM-5 in training, research, or applied settings.

The email invitation indicated that the purpose of the anonymous survey was to gather information about psychologists' attitudes toward diagnosis and DSM. Respondents were informed that participation was voluntary, completing all survey items was not required, and they could stop at any time. Data collection occurred between March 15 and May 15, 2019. Data and materials are available upon request. The study was not preregistered.

Of the total number of respondents, only the data of those who had completed a doctoral degree (Ph.D., Psy.D., or Ed.D.), were licensed psychologists, and had completed at least 75% of the non-demographic items were included in the analysis. This yielded 703 participants (including 538 clinical psychologists, 93 counseling psychologists, 25 school psychologists, and 45 who selected "other"). Table 1 provides participant demographic information. For our analyses, the theoretical orientations in Table 1 were grouped as follows: Cognitive-behavioral therapy (CBT) comprised participants identifying with the cognitive-behavioral and REBT orientations (*n* = 268)*;* psychodynamic comprised participants identifying with the psychodynamic and interpersonal orientations (*n* = 157); humanistic/constructivist/systems (HCS) comprised participants identifying with the Adlerian, constructivist, family systems, feminist, gestalt, humanistic/existential, and reality-therapy orientations, (*n* = 91); and integrative/eclectic comprised participants identifying with the integrative and eclectic orientations (*n* = 174).

Results

Analyses are grouped by the areas surveyed: (a) use of DSM-5, (b) attitudes about DSM-5, (c) attitudes about alternatives to DSM-5, and (d) general attitudes about diagnosis and DSM. Attitudes of the full sample were compared to the unlabeled midpoint of 8 on the various 15-point scales using one-sample t-tests. Sample sizes vary across analyses because some participants did not provide responses to all items. Because of the large number of inferential tests conducted, we set the alpha level for significance for each individual test at a conservative $\alpha = .001$.

Use of DSM-5

Monthly use. Participants estimated via two structured fill-in response items how many times each month they relied on DSM-5 directly (e.g., for classifying clients and/or communicating their diagnosis) and indirectly (e.g., to form hypotheses or conceptualize a client). A large majority used DSM-5 directly or indirectly at least once a month (88.1%, slightly fewer than the over 90% expected).

Reasons for use. A multiple response item with 13 options (including "other," where reasons could be provided) asked "Why do you use the DSM-5?" Consistent with expectations, the two reasons selected by more than half of the 698 participants who responded were "required by third-party payers" (62.32%) and "to help make a differential diagnosis" (59.46%). Other reasons for use, from most to least popular, were "to help conceptualize a case" (39.83%), "I find it useful" (30.52%), "to help determine treatment" (27.51%), "only classification system presently available" (20.77%), "required by employer" (15.90%), "other" (13.90%), "to help arrive at a prognosis" (10.60%), "required by law" (9.31%), "to aid in research" (8.31%), "because of its reliability" (7.45%), "because psychiatrists use it" (7.02%), and "because of its validity" (6.02%).

Attitudes About DSM-5

Overall satisfaction and satisfaction by theoretical orientation. Participants responded to the question "Overall, what best describes your attitude toward DSM-5?" using a 15-point visual analogue scale with the following anchors: 1-2 (*very unsatisfied*), 5-6 (*unsatisfied*), 10-11 (*satisfied*), 14-15 (*very satisfied*). As expected, results of a one-sample t-test found that, overall, respondents were dissatisfied with DSM-5 (details in Table 2), although the mean was relatively close to the midpoint and the effect was small. To test our prediction that attitudes would differ by theoretical orientation, we analyzed overall satisfaction separately for each theoretical grouping (CBT, psychodynamic, humanistic/constructivist/systems, and integrative/eclectic). As expected, in their attitude toward DSM-5, CBT psychologists were satisfied, psychodynamic and humanistic/constructivist/systems psychologists were dissatisfied, and integrative/eclectic psychologists were neutral (see Table 2).

Perceived advantages and disadvantages. Participants were asked "Which do you see as advantages of the DSM-5?" and "Which do you see as disadvantages of the DSM-5?" For both these questions, they were provided a multiple response list of 10 items plus an "other" option where they could write in additional answers. The only advantage endorsed by more than half of the 680 first

question respondents was “diagnostic codes” (54.71%), followed by “helps identify pathology” (44.26%), “diagnostic classification often leads to most appropriate treatment” (35.29%), “atheoretical stance regarding etiology of disorders” (23.97%), “has direct bearing on treatment” (19.26%), “other” (17.65%), “is reliable” (17.35%), “increased use of dimensional measures” (14.85%), “is valid” (12.50%), and “multiaxial diagnosis” (11.03%). The three disadvantages identified by more than half of the 681 respondents to the second question were “applies medical labels to psychosocial problems” (55.21%), “obscures individual differences” (53.74%), and “disagreement over what categories belong in the manual” (52.86%). Other disadvantages, from most to least frequently selected, were “places more emphasis on diagnosis than treatment” (45.96%), “places too much emphasis on pathology” (39.35%), “labels distort one’s perceptions of a client” (38.08%), “has little bearing on treatment” (35.83%), “not reliable” (27.75%), “not valid” (28.34%), “diagnostic classification often leads to inappropriate treatment” (18.36%), and “other” (16.30%).

Effects on diagnosis and psychologists. Participants were asked “In your professional opinion, what has been the DSM-5’s effect on diagnosis?” and “What has the effect of DSM-5 been on psychologists?” They responded to these items using 15-point visual analogue scales. The first scale was labeled 1-2 (*significantly hindered*), 5-6 (*hindered*), 10-11 (*improved*), 14-15 (*significantly improved*); the second was labeled 1-2 (*significant harm*), 5-6 (*harm*), 10-11 (*benefit*), 14-15 (*significant benefit*). Contrary to predictions, a one-sample t-test yielded a non-significant effect for the first item, with respondents on average indicating that DSM-5 had not affected diagnosis (see Table 2). There was one exception to this by theoretical orientation. Participants with a CBT orientation said the DSM-5 had an overall positive effect upon diagnosis; no other orientation differed significantly from the midpoint. For the second item, a one-sample t-test confirmed our prediction that participants’ mean ratings of DSM-5’s effect on them would not significantly differ from neutral (again, see Table 2). That is, respndents did not rate the DSM-5 as either harming or benefiting their profession. However, views on the effect of

DSM-5 on psychologists differed depending on theoretical orientation. Those with a CBT orientation indicated that DSM-5 benefited psychologists, whereas those with a psychodynamic or humanistic/constructivist/systems orientation felt it had a harmful effect. Psychologists with an integrative/eclectic orientation were neutral on this issue.

Attitudes About Alternatives to DSM-5

General support for alternatives. Participants were asked "Would you support seeing an alternative diagnostic system to the DSM gain influence?" and responded using a 15-point visual analogue scale with the following labels: 1-2 (*strongly oppose*), 5-6 (*oppose*), 10-11 (*support*), 14-15 (*strongly support*). A one-sample t-test found a large and significant effect for respondents supporting the development of alternatives to DSM-5. These results, included in Table 2, also held for all four theoretical orientation groupings analyzed separately (all *p*s < .001, *d*s ranged from .63 to 1.21).

Familiarity with alternatives. Participants rated their familiarity with ICD, PDM, OPD, RDoC, HiTOP, and PTMF, using 15-point visual analogue scales with the following labels: 1-2 (*thoroughly unfamiliar*), 5-6 (*unfamiliar*), 10-11 (*familiar*), 14-15 (*thoroughly familiar*). One-sample t-tests found significant and large effects (see Table 3). Consistent with predictions, participants on average were familiar with ICD. However, they were unfamiliar with PDM, OPD, RDoC, HiTOP and PTMF. These findings held for all theoretical orientations, with one exception. Unlike other participants, those with a psychodynamic orientation did not differ from the neutral midpoint in rating their familiarity with the PDM.

A repeated measures ANOVA (with a Greenhouse-Geisser correction for any deviation from sphericity) revealed significant differences in mean familiarity across the various alternatives to DSM-5, $F(3.30, 2278.56) = 1111.96$, $p < .001$. Participants were much more familiar with the ICD than any other alternative (Tukey *p*s all < .001, *d*s ranging from 1.22 to 2.94). Differences in familiarity among the other five alternatives were also significant (Tukey *p*s all < .001, except for a non-significant difference

between familiarity with HiTOP and OPD, p = .507), but with much smaller effect sizes (ds ranging from 0.07 to 0.67). Among these less well-known alternatives, participants were most familiar with PDM (due largely to its familiarity among respondents with a psychodynamic orientation), followed by RDoC, HiTOP and OPD, and finally PTMF.

Support for specific alternatives. Participants were asked to rate their support for the development and use of ICD, PDM, OPD, RDoC, HiTOP, and PTMF as alternatives to DSM. There were two items per alternative, the first regarding support for development and the second regarding support for use. Responses to both used a 15-point visual analogue scale labeled 1-2 (*strongly oppose*), 5-6 (*oppose*), 10-11 (*support*), 14-15 (*strongly support*). Because participants' support for development and support for use of each alternative were highly correlated (all rs > .80), these pairs of items were averaged to create a single support index for each alternative. As shown in Table 3, the only alternative that participants supported was ICD. A significant lack of support was found for RDoC, OPD, HiTOP, PTMF, and PDM, with effect sizes being notably smaller for PDM (d = .38) than the others (all ds > .6). After rating their degree of support for developing these alternatives, participants used the same scale to rate whether they preferred the development and use of DSM—which they did not. Contrary to predictions, respondents did not prefer the development and use of DSM over its alternatives, although this effect was small. Thus, the psychologists surveyed did not support developing or using DSM or any of its alternatives besides ICD.

Support by theoretical orientation. We also analyzed support for DSM and its alternatives separately for each of the four theoretical orientations, as shown in Table 3. CBT and integrative/eclectic psychologists were neutral toward DSM and supportive of ICD, whereas psychodynamic and humanistic/constructivist/systems psychologists were unsupportive of DSM and neutral toward ICD. Unsurprisingly, psychodynamic psychologists somewhat liked psychodynamic alternatives; they supported PDM and were neutral toward OPD. By contrast, psychologists from the other three

orientations did not support either of these alternatives. Finally, there was a lack of support from all orientations for RDoC, HiTOP and PTMF, consistent with respondent attitudes in general.

General Attitudes about Diagnosis and DSM

To explore psychologists' general attitudes about diagnosis and DSM, participants were asked to rate six items on 15-point visual analogue scales labeled as follows around an unlabeled midpoint: 1-2 (*strongly disagree*), 5-6 (*disagree*), 10-11 (*agree*), 14-15 (*strongly agree*). As with the other VAS items, one sample t-tests were used to compare group means to the neutral point (8) on the 15-point scale. Results were significant for four of the six items (see Table 2). There was a small to medium effect for respondents disagreeing with the statement "mental disorders are a subset of medical disorders." Consistent with this, participants agreed that "DSM relies too heavily on medical semantics," (a small effect); and that "too little has been done to promote a scientific alternative to the DSM," (a medium effect). However, they were neutral regarding two statements critical of the medical model: "clients' welfare would be better served by abandoning the medical model in training and practice," and "most conditions that DSM labels as mental disorders can best be described as nonmedical problems in living." These results were consistent with predictions. Finally, despite any concerns they had about DSM, there was a small but significant effect for respondents disagreeing with the statement "psychologists have lost their autonomy because of the widespread influence of the DSM."

In terms of theoretical orientation, CBT psychologists generally held more positive attitudes toward DSM than psychodynamic, humanistic/constructivist/systems, or integrative/eclectic psychologists (see Table 2). For example, CBT psychologists were neutral on whether "mental disorders are a subset of medical disorders," whereas participants from the other three orientations disagreed with this statement. Similarly, CBT psychologists did not agree that "DSM relies too heavily on medical semantics," but psychologists from all other orientations did. Furthermore, CBT was the only orientation to disagree that "clients' welfare would be better served by abandoning the medical model in training in

practice" (those with a psychodynamic orientation agreed with this), that "most conditions that DSM labels as mental disorders can best be described as nonmedical problems in living" (those with a humanistic/constructivist/systems orientation agreed), and that "psychologists have lost their autonomy because of the widespread influence of the DSM." Thus, predictions about the attitudes of CBT, psychodynamic, and humanistic/constructivist/systems psychologists were fully supported. By comparison, predictions for integrative/eclectic psychologists were only partially supported, as they had more neutral-to-negative attitudes than expected. Finally, consistent with predictions, participants from all orientations agreed that "too little has been done to promote a scientific alternative to the DSM."

Discussion

DSM: Mixed Views, Widely Used

This study found something remarkable—namely that psychologist attitudes toward DSM today are largely the same as they were when the seminal DSM-III debuted in the early 1980s. The manual has gone through five revisions since then to refine and improve it. However, during that time span, psychologists have remained largely unenthusiastic. As was true 40+ years ago, psychologists as a group are more dissatisfied than satisfied with DSM. Further, they do not think the manual has had much effect on them or diagnosis. This is an important finding worthy of attention. Why, after nearly a half century of continuous efforts to improve DSM, do psychologists overall remain equivocal?

At a more granular level, things get more nuanced, with psychologists' opinions differing by theoretical orientation. CBT psychologists generally like DSM-5, believe it has had a positive effect on psychologists and diagnosis, and do not think it relies too heavily on medical semantics or has limited their autonomy. By contrast, psychodynamic and humanistic/constructivist/systems psychologists dislike the manual on average, see it as having had a negative effect on psychologists (if not on diagnosis and their autonomy), and believe it relies too heavily on medical semantics. The attitudes of integrative/eclectic psychologists lie in between. They are neutral in their overall attitude toward DSM-5

and their perception of its effects on diagnosis, psychologists, and their professional autonomy. However, they agree with psychodynamic and humanistic/constructivist/systems psychologists that DSM overemphasizes medical semantics. This affirms common assumptions about what psychologists of different orientations think of DSM. The manual's medical model approach conflicts with many of the theoretical commitments adhered to by psychodynamic and humanistic psychologists, who have actively resisted it or developed alternatives to it (e.g., Elkins, 2016; Johnstone et al., 2018; Kamens et al., 2017; Wallerstein, 2011); therefore, they dislike DSM and feel frustrated with each revision. By comparison, CBT psychologists, with their focus on observable and measurable behavior, are generally better aligned with DSM assumptions. They regularly use the manual's diagnoses when researching CBT interventions (e.g., Cheng et al., 2019; Hancock et al., 2018; O'Mahen et al, 2021; Wood et al., 2015); thus, they view DSM positively and see each new version as making incremental improvements.

What remains fascinating is that despite the negative if varied attitudes toward DSM-5 expressed by survey respondents, they overwhelmingly used it—88% at least once monthly, only slightly lower than the over 90% expected. This probably comes as little surprise to practicing psychologists. As our data implies, the reasons psychologists use DSM are primarily practical rather than due to liking the manual. To wit, the only perceived DSM-5 advantage identified by more than half the participants was the diagnostic codes used for third-party payments—an implicit acknowledgment that psychologists mainly value the nomenclature as a means to get paid. Tellingly, the disadvantages noted by over half the participants point to apprehension about the scientific standing of DSM (disagreement over what categories belong in it) and the manual's effects on those diagnosed (concern that it applies medical labels to psychosocial problems and obscures individual differences). Thus, despite differences in attitudes toward the manual by theoretical orientation—with some liking it and others disliking it, psychologists overall are aware of DSM's practical advantages and limitations.

Alternatives: Desired in Theory, Unknown and Unsupported in Practice

A second remarkable finding is that psychologists are hungry for alternatives to DSM but know little about those that currently exist. Regardless of their attitudes toward DSM-5, respondents in general and across all theoretical orientations endorsed the statement that "too little has been done to promote a scientific alternative to the DSM." They also expressed support for developing such alternatives. However, when asked about specific alternatives, their enthusiasm waned—probably because they were largely unfamiliar with the alternatives presented. Except for ICD (discussed more below), psychologists were largely unfamiliar with PDM, RDoC, HiTOP, OPD, and PTMF. Thus, it makes sense that they did not support their development and use; they were likely wary of initiatives about which they knew very little. Interestingly, lack of support for these five unfamiliar alternatives cut across theoretical orientations, with one notable exception: Psychodynamic psychologists were vaguely familiar with PDM, a diagnostic alternative rooted in their theoretical orientation, and this might have informed their support for its development and use. They weren't as familiar with the other psychodynamic diagnostic scheme, the OPD, but they knew enough about it to be neutral rather than negative in their support for it. As with many things, when it comes to supporting diagnostic alternatives, familiarity may breed liking.

This certainly appears to be the case with ICD, the only diagnostic alternative that psychologists were familiar with and, if they were CBT or integrative/eclectic, supportive of developing and using. Of course, ICD might not be viewed by psychologists as a meaningfully different system from the DSM. This could explain psychologists' comfort with it. Familiarity with ICD is also not surprising given that it has received ample attention from the American Psychological Association in recent years, is harmonized with DSM, and provides the critically important diagnostic codes (which DSM borrows) that American clinicians use to bill third-party payers (Goodheart, 2014). If it is true that with familiarity comes liking and acceptance, then ICD's level of support makes sense. Even psychodynamic and

humanistic/constructivist/systems psychologists, who are theoretically disinclined toward ICD due to its strong family resemblance to DSM, were neutral (rather than negative) about its development and use. Despite ICD's similarity to DSM, some psychologists might prefer it to DSM due to it being freely available, internationally authored, and less hegemonic. However, to feel this way, they had to be familiar with and know about ICD, which again supports the possibility that psychologists remain unsupportive of most alternatives simply because they do not know much about them.

Beyond our general sense that psychologists were reticent to embrace alternatives they did not know much about, what else might psychologists dislike about the available alternatives? PDM, with its psychological orientation to diagnosis (Lingiardi & McWilliams, 2017), seems like it could appeal to many psychologists, but—besides the already noted exception of psychodynamic psychologists—those surveyed were unfamiliar with it or OPD, the other psychodynamic diagnostic system about which they were asked. Perhaps these manuals' lack of diagnostic codes and their marketing as psychodynamic-specific manuals makes them a tough sell for many psychologists, who therefore have not invested time to learn about them.

Quite different from PDM and OPD is RDoC, the National Institute of Mental Health (NIMH) research initiative to develop a biomarker-based diagnostic system (Cuthbert, 2014). As an ongoing research project, RDoC does not currently offer a concrete diagnostic system to psychologists. Given the finding that psychologists value DSM-5's utilitarian advantages (e.g., useable categories and codes), a not-yet-ready-for-implementation research initiative might not interest them.

HiTOP, which combines cooccurring symptoms into diagnostic spectra dimensions (Kotov et al., 2021), is relatively new and has received little attention, perhaps explaining its lack of familiarity and support among psychologists. We wonder if HiTOP's reliance on spectra dimensions rather than categories (as well as its lack of diagnostic codes) might hamper it. Psychologists more familiar with

HiTOP may have been concerned about questions over its readiness for use in clinical settings (Haeffel et al., 2021).

Finally, American psychologists were least familiar with the British Psychological Society's PTMF; given that PTMF rejects the idea of diagnosis and instead proposes a more collaborative formulation approach that stresses sociocultural factors in the development of mental distress (Johnstone et al., 2018), many psychologists may find it a bridge too far as an alternative to DSM-5. However, as noted, we suspect lack of support for unfamiliar DSM-5 alternatives was primarily a function of respondents not knowing enough about them to endorse their development or use.

Support among those familiar with alternatives. Of the alternatives included in the survey, 89.74% of respondents were familiar with ICD, whose development and use they supported. Only 25.61% of participants were familiar with PDM and 16.86% with RDoC. The other alternatives were virtually unknown to psychologists; just 6.17% were familiar with HiTOP, 4.16% with OPD, and 1.01% with PTMF. Given our suspicion that familiarity breeds liking, we were curious whether the small percentages of respondents who said they were familiar with these less well-known alternatives (by rating themselves above the neutral midpoint of 8 on the 15-point familiarity scale) supported their development and use. We informally explored this and found preliminary evidence that they did. When psychologists were familiar with an alternative, their mean attitudes for development/use of that alternative were above the neutral midpoint. Specifically, they were well above neutral for ICD (n = 630; M = 10.15, SD = 3.71), PDM (n = 175; M = 11.25, SD = 3.93), HiTOP (n = 43; M = 11.06, SD = 2.22), and PTMF (n = 6; M = 11.53, SD = 5.33); they were somewhat above neutral for OPD (n = 24; M = 8.77, SD = 4.86). The only alternative where the development/use score was barely above the midpoint was RDoC (n = 109; M = 8.07, SD = 3.80)—which makes sense given that RDoC is merely a research initiative at this time, thus psychologists have a logical reason to not yet recommend using it. Obviously, for some diagnostic alternatives (HiTOP, OPD, and PTMF) the number of participants familiar with them was

miniscule. Nonetheless, this informal exploratory follow-up suggests that future research should examine whether support for the development and use of alternatives to DSM-5 increases as psychologists gain familiarity with them.

General Attitudes: Disagreement Over the Medical Model

As already mentioned, psychologists overall felt DSM relies too heavily on medical semantics, with CBT as the only theoretical orientation whose adherents did not endorse this sentiment. A similar pattern characterizes psychologist attitudes toward the medical model. It makes sense that many psychologists view DSM as a medical model manual; although it does not define disorders etiologically using biomarkers (because it currently lacks the ability to), it is authored by medical doctors, organizes symptoms into discrete diagnostic entities, and presumes these categories reflect dysfunctions in the biological, psychological, or developmental processes of the person (APA, 2022). However, survey respondents as a group disagreed with the notion that mental disorders are a subset of medical disorders. Yet once again there were differences by theoretical bent. While psychodynamic, humanistic/constructivist/systems, and integrative/eclectic psychologists all felt this way, CBT psychologists were neutral on the subject. Tellingly, there were limits to psychologists' rejection of the medical model. Despite many of them being skeptical of it, as a group they declined to endorse the idea that most mental disorders should be reframed as nonmedical problems in living—a clear shift from the 1980s, when surveyed psychologists embraced such a view (Smith & Kraft, 1983). In fact, the only psychologists who did embrace this stance were the ones we would most expect to do so, the humanistic/constructivists/systems psychologists.

The overall pattern is intriguing. Psychologists do not see mental disorders as a subset of medical disorders but are unprepared to recast most of them as nonmedical life problems. This suggests a subtle but difficult-to-communicate view among psychologists that what DSM identifies as mental disorders are more than just life problems but not quite medical diseases. Considering this, it seems fair

to postulate that greater familiarity with alternatives to DSM such as HiTOP and PDM, which "psychologize" presenting problems using the language of personality assessment and psychodynamic/psychotherapeutic theory, respectively, could help psychologists articulate a view of psychopathology that does not merely equate it with medical illness. For this to occur would require better acquainting psychologists with these currently little-known diagnostic initiatives.

It also might make sense to shift away from a "one size fits all" approach to diagnosis. Beyond the very practical need to get psychologists paid by insurance companies (something none of the alternatives except ICD can do as well or better than DSM), diagnosis serves different purposes for clinicians depending on their theoretical orientation. Our study offers preliminary evidence that psychodynamic psychologists familiar with PDM and OPD are more inclined toward these approaches. It is not much of a stretch, then, to think that psychologists with an interest in personality assessment might find themselves drawn to HiTOP. Likewise, if humanistic/constructivist/systems psychologists become better acquainted with PTMF—a system that, like them, is highly critical of the medical model—perhaps there is a niche for that approach, as well. Summing up, if the alternatives in our study can gain traction, psychologist preferences for them will likely vary by theoretical orientation. We see this as a good thing because it encourages creativity and innovation in the diagnostic arena, potentially providing a panoply of empirically supported and useful diagnostic methods. Diversity of diagnostic options is not something psychologists are accustomed to given DSM's long dominance, but it could prove beneficial to clients and practitioners alike. After all, if different types of psychotherapy are equally effective (Wampold & Imel, 2015), cannot different diagnostic systems be so, too?

Implications for Education and Training

Respondents were desirous of but largely unfamiliar with alternatives to DSM, despite a growing body of rigorous scholarship on them (Conway et al., 2022; Cuthbert, 2022; Harper & Cromby, 2022; Huprich et al., 2019; Polychronis & Keyes, 2022). This finding should serve as a clarion call for education

and training. Practicing psychologists know little about DSM alternatives, but continuing education and training workshops could rectify this. Further, incorporating coverage into APA-accredited curricula would ensure that the next generation of psychologists are well-versed in research and practice issues pertinent to alternative forms of diagnosis. As psychologists become trained in these approaches, their attitudes about them will likely evolve. Future research should assess how attitudes toward specific alternatives change as relevant education and training are implemented.

Study Limitations

Because many participants who started the survey did not complete it, we excluded data of those who responded to less than 75% of the non-demographic items. It is possible that the attitudes of those whose data was omitted differ from those whose data was analyzed. Additionally, survey data relies on participants honestly and accurately self-reporting; some might not have. Another potential limitation is that some participants might have incorrectly recalled how and why they use DSM, possibly skewing results. Finally, recruiting participants from lists of APA divisions could have introduced bias into the results, as many APA members belong to no divisions and therefore were excluded from the pool of prospective participants. Further, APS members were not included—and they might have different attitudes toward diagnosis or be more familiar with alternatives. The study also does not explore how years of practice, practice setting, and whether the clinician works primarily with adults or children might have impacted attitudes—something future research should examine.

Conclusion

This study is important because it is the first since the publication of DSM-5 to show that psychologists continue to have mixed attitudes about DSM—as they have since the "DSM era" began in the early 1980s. Apart from those embracing a CBT perspective, they are not enthusiastic about DSM-5 but they still use it—more so for practical reasons like diagnostic codes that foster third-party reimbursement than scientific ones like validity or reliability; this reluctant use is likely to continue with

the new DSM-5-TR. Further, as they have since the early 1980s, psychologists of all theoretical stripes also support developing alternatives to DSM—at least in the abstract. Yet they know very little about existing alternatives, which makes supporting and using them difficult. The current study suggests there is a hunger for alternatives, but the practical obstacles alternatives must overcome are daunting. Successful alternatives must not only gain familiarity and theoretically appeal to one or more niche groups of psychologists but must also provide the same practical benefits as DSM—or find a practical way to coexist with DSM on the reimbursement front while offering something clinicians find useful. Until alternatives overcome these obstacles, it is doubtful that psychologists will embrace them regardless of their scientific bona fides. Even if they do overcome them, it will be necessary to supplement research and development with education and training initiatives. In the meantime, we expect psychologists to continue using the DSM despite their lack of strong enthusiasm for it.

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Table 1

Summary Demographic Characteristics of Sample

Variable		*Variable*	
Age		**Primary Work Setting**	
Mean Age in Years (SD)	57.41 (14.37)	Unknown/Not Answered	4 (0.57%)
Number of Respondents	703	Academic Dept. College/University	120 (17.07%)
Unknown/Not answered	12	Community Mental Health Agency	30 (4.27%)
		Hospital	72 (10.24%)
Gender		Private Practice	348 (49.50%)
Unknown/Not Answered	17 (2.42%)	Univ. Counseling/Health Center	27 (3.84%)
Female	339 (48.22%)	Other	102 (14.51%)
Male	344 (48.93%)		
Non-binary	3 (0.43%)	**Primary Theoretical Orientation**	
		Unknown/Not Answered	3 (0.43%)
Ethnicity		Adlerian	2 (0.28%)
Unknown/Not Answered	5 (0.71%)	Cognitive-Behavioral	251 (35.70%)
Asian/Asian American	14 (1.99%)	Constructivist	15 (2.13%)
Black/African American	13 (1.85%)	Eclectic	56 (7.87%)
Caucasian/White	622 (88.48%)	Family Systems	12 (1.71%)
Hispanic/Latino	20 (2.84%)	Feminist	3 (0.43%)
Native American	5 (0.71%)	Gestalt	1 (0.14%)
Other	24 (3.41%)	Humanistic/Existential	39 (5.55%)
		Integrative	96 (13.66%)
Highest Degree Earned		Interpersonal	16 (2.28%)
Ed.D.	18 (2.56%)	Psychodynamic	137 (19.49%)
Ph.D.	530 (75.39%)	REBT	3 (0.43%)
Psy.D.	155 (22.05%)	Solution-Focused	11 (1.56%)
		Other	58 (8.25%)
Primary Work Activity			
Administration	21 (2.99%)	**Professional Identification**	
Applied Practice	503 (71.55%)	Unknown/Not Answered	2 (0.28%)
Consultation	33 (4.69%)	Clinical Psychology	538 (76.53%)
Research	44 (6.26%)	Counseling Psychology	93 (13.23%)
Supervision	19 (2.70%)	School Psychology	25 (3.56%)
Teaching	63 (8.96%)	Other	45 (6.40%)
Other	20 (2.84%)		

Table 2

DSM-5 Attitudes by Theoretical Orientation

Item	*M (SD)* *d*				
	Total Sample (n = 703)	CBT (*n* = 268)	Psychodynamic (*n* = 157)	Humanistic/ Constructivist/ Systems (*n* = 91)	Integrative/ Eclectic (*n* = 174)
Attitude toward DSM-5	7.55^{L} (3.66) *d* = .12	8.76^{H} (3.12) *d* = .24	6.75^{L} (3.81) *d* = .33	5.23^{L} (3.64) *d* = .76	7.51 (3.57) *d* = .14
Effect of DSM-5 on diagnosis	8.29 (3.19) *d* = .09	9.29^{H} (2.83) *d* = .45	7.38 (3.33) *d* = .19	6.89 (3.22) *d* = .35	8.23 (3.10) *d* = .07
Effect of DSM-5 on psychologists	8.02 (3.16) *d* = .01	9.01^{H} (2.68) *d* = .40	7.11^{L} (3.29) *d* = .27	6.36^{L} (3.40) *d* = .48	7.99 (3.02) *d* = .00
Support for alternative diagnostic systems	11.07^{H} (3.55) *d* = .87	10.24^{H} (3.58) *d* = .63	11.84^{H} (3.17) *d* = 1.21	11.76^{H} (3.97) *d* = .95	11.46^{H} (3.25) *d* = 1.06
Mental disorders are a subset of medical disorders.	6.64^{L} (3.70) *d* = .37	7.46 (3.80) *d* = .14	5.30^{L} (3.27) *d* = .83	6.08^{L} (3.48) *d* = .55	6.87^{L} (3.70) *d* = .31
DSM relies too heavily on medical semantics.	9.03^{H} (3.95) *d* = .26	8.16 (3.68) *d* = .04	9.66^{H} (4.11) *d* = .40	10.95^{H} (3.78) *d* = .78	9.05^{H} (3.84) *d* = .27
Clients' welfare would be better served by abandoning the medical model in training and practice.	7.92 (4.03) *d* = .02	6.61^{L} (3.89) *d* = .36	9.03^{H} (3.74) *d* = .28	9.35 (4.01) *d* = .34	8.30 (3.89) *d* = .08
Most conditions that DSM labels as mental disorders can best be described as nonmedical problems in living.	7.61 (3.99) *d* = .10	6.59^{L} (3.73) *d* = .38	8.09 (4.05) *d* = .02	9.55^{H} (4.13) *d* = .38	7.76 (3.81) *d* = .06
Psychologists have lost their autonomy because of the widespread influence of the DSM.	7.14^{L} (4.38) *d* = .20	5.79^{L} (3.95) *d* = .56	7.96 (4.46) *d* = .01	9.20 (4.46) *d* = .27	7.48 (4.39) *d* = .12
Too little has been done to promote a scientific alternative to the DSM.	10.05^{H} (4.26) *d* = .48	9.34^{H} (4.35) *d* = .31	10.21^{H} (4.15) *d* = .53	11.97^{H} (3.70) *d* = 1.07	10.11^{H} (4.17) *d* = .51

Note: ^{H} value is significantly higher than the mid-point of 8 at $p < .001$; ^{L} value is significantly lower than the mid-point of 8 at $p < .001$

Table 3

Familiarity and Support for DSM-5 and Alternatives by Theoretical Orientation

Item		*M (SD)* *d* Total Sample (*n* = 703)	CBT (*n* = 268)	Psychodynamic (*n* = 157)	Humanistic/ Constructivist/ Systems (*n* = 91)	Integrative/ Eclectic (*n* = 174)
DSM-5	Support	7.13^{L} (4.60) *d* = .19	8.30 (4.55) *d* = .07	5.88^{L} (4.43) *d* = .48	4.93^{L} (4.55) *d* = .73	7.14 (4.38) *d* = .20
ICD	Familiarity	11.31^{H} (2.90) *d* = 1.14	11.77^{H} (2.59) *d* = 1.46	10.28^{H} (3.00) *d* = .76	11.72^{H} (3.02) *d* = 1.23	11.41^{H} (2.96) *d* = 1.15
	Support	9.84^{H} (3.77) *d* = .49	10.83^{H} (3.43) *d* = .82	8.02 (3.72) *d* = .00	9.03 (4.04) *d* = .26	10.22^{H} (3.60) *d* = .62
PDM	Familiarity	4.91^{L} (4.45) *d* = .70	2.96^{L} (2.80) *d* = 1.80	8.82 (4.75) *d* = .17	4.34^{L} (4.06) *d* = .90	4.81^{L} (4.27) *d* = .75
	Support	6.16^{L} (4.89) *d* = .38	3.54^{L} (3.36) *d* = 1.33	10.91^{H} (4.18) *d* = .70	5.69^{L} (4.59) *d* = .50	6.23^{L} (4.56) *d* = .38
OPD	Familiarity	2.34^{L} (2.14) *d* = 2.64	2.17^{L} (1.87) *d* = 3.12	2.69^{L} (2.58) *d* = 2.06	2.40^{L} (2.37) *d* = 2.36	2.27^{L} (1.96) *d* = 2.93
	Support	4.79^{L} (3.97) *d* = .81	3.33^{L} (3.04) *d* = 1.54	6.77 (4.47) *d* = .28	5.14^{L} (4.18) *d* = .68	5.37^{L} (3.96) *d* = .67
RDoC	Familiarity	3.77^{L} (3.74) *d* = 1.13	4.63^{L} (4.28) *d* = .79	3.09^{L} (3.25) *d* = 1.51	3.68^{L} (3.58) *d* = 1.21	3.17^{L} (3.13) *d* = 1.55
	Support	5.54^{L} (3.82) *d* = .64	5.85^{L} (4.08) *d* = .53	4.34^{L} (3.10) *d* = 1.18	5.85^{L} (4.00) *d* = .64	5.75^{L} (3.71) *d* = .61
HiTOP	Familiarity	2.52^{L} (2.61) *d* = 2.10	2.74^{L} (2.92) *d* = 1.80	2.17^{L} (2.04) *d* = 2.85	2.81^{L} (3.13) *d* = 1.66	2.38^{L} (2.25) *d* = 2.50
	Support	4.76^{L} (3.58) *d* = .91	4.60^{L} (3.77) *d* = 1.49	4.21^{L} (3.11) *d* = 1.22	5.51^{L} (3.90) *d* = .62	4.99^{L} (3.39) *d* = .89
PTMF	Familiarity	1.92^{L} (1.57) *d* = 3.88	1.85^{L} (1.29) *d* = 4.78	1.81^{L} (1.48) *d* = 4.19	2.12^{L} (2.11) *d* = 2.79	1.98^{L} (1.69) *d* = 3.57
	Support	4.04^{L} (3.34) *d* = 1.19	3.51^{L} (3.02) *d* = 1.49	3.80^{L} (2.98) *d* = 1.41	5.35^{L} (4.31) *d* = .55	4.38^{L} (3.35) *d* = 1.08

Note: ^{H} value is significantly higher than the mid-point of 8 at $p < .001$; ^{L} value is significantly lower than the mid-point of 8 at $p < .001$