1

Diagnosis and the Social Work Profession

Competencies Applied with Practice Behaviors — in this Chapter				
■ Professional Identity	■ Ethical Practice	✖ Critical Thinking	✖ Diversity in Practice	■ Human Rights and Justice
✖ Research-Based Practice	■ Human Behavior	■ Policy Practice	■ Practice Contexts	■ Engage, Assess, Intervene, Evaluate

Henry Williams, a 59-year-old African American man, was in the hospital after undergoing surgery for removal of a brain tumor. His past medical history included seizures, insulin-dependent diabetes mellitus, and pancreatitis (an inflammation of the pancreas that causes intense pain in the upper abdomen). Currently, Mr. Williams was taking several medications, including Dilantin (used to treat epilepsy), insulin, and steroids (to decrease swelling around his tumor).

About six days after the surgery Mr. Williams woke up in the middle of the night and was very loud in "casting the demons out," as he called it. The nurse tried to calm him, but Mr. Williams was so incensed that he picked up a small monitoring machine next to his bed and threw it at her. Security officers and the on-duty physician assistant were called to calm the patient.

The next morning the neurosurgery team requested a psychiatric exam, but because it was a Friday Mr. Williams was not examined until the following Monday. His family visited over the weekend, and he repeatedly became agitated, even accusing his wife of cheating on him. He was upset and emotional during those visits, and it took him a while to calm down after his family left.

On Sunday night, Mr. Williams got up at midnight and threatened his roommate. Mr. Williams yelled that his roommate was cheating on him with his wife and they were plotting to kill him. Because his roommate feared for his safety, he was moved to another room, while the nurse tried to calm Mr. Williams.

When the psychiatric team, accompanied by the social work intern, finally examined Mr. Williams, he said he felt great but was hearing voices, most prominently that of his

pastor. He reported that he saw demons at night and was attempting to fight them off. He also stated that he thought someone wanted to kill him to benefit from his life insurance policy. In addition, Mr. Williams told the psychiatrist that his wife had not come to visit him for some days (this was not true; she had been there twice over the weekend) but that his son had been at his bedside in the morning and that he had enjoyed the visit.

Mr. Williams's wife heard about the incident with the roommate and said she would not take Mr. Williams home because she was afraid of him. She told the social work intern that Mr. Williams had behaved similarly in the past. She would sometimes wake up in the middle of the night and find him standing next to the bed or leaning over her body, staring at her. When she confronted her husband, he would pass it off as a joke, saying he was making sure she was really in bed and had not gone out. (They had separate bedrooms.) She also told the intern that although she had never cheated on her husband, he had had an affair several years ago. After she found out, they went to marriage counseling together, but the marriage had been "rocky" ever since.

The case described earlier is one in which the client, Mr. Williams, appears to have a mental disorder. Almost half of all Americans (46.4%) meet the criteria for a mental, emotional, or behavioral disorder sometime during their lives (Kessler, Berglund, Demler, Jin, & Walters, 2005). The various disorders are catalogued and described in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), published by the American Psychiatric Association (APA). The DSM is the standard resource for clinical diagnosis in the United States. The first edition of the DSM was published in 1952, and the manual has undergone many revisions during the last 59 years. The latest version is *DSM-IV-TR* (Text Revision) (American Psychiatric Association [APA], 2000), and another revision is planned for 2013.

The definition of *mental disorder* in the DSM is a "significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom" (p. xxxi). A disorder ". . . must currently be considered a manifestation of behavioral, psychological, or biological dysfunction in the individual" (p. xxxi). The DSM represents a medical perspective, only one of many possible perspectives on human behavior. The medical definition focuses on underlying disturbances *within* the person and is sometimes referred to as the *disease model* of abnormality. This model implies that the abnormal person must experience changes within the self (rather than create environmental change) in order to be considered "normal" again.

In its desire to promote the "objectivity" of its manual, the APA does not recognize the notion of mental illness as a *social construction*. A social construction is any belief system in a culture that is accepted as factual or objective by many of its members, when in fact the belief system is constructed by influential members of that society (Farone, 2003). The medical profession holds great influence in Western society, so when mental health diagnoses are presented as scientifically based disorders, many people will accept them as such. Social constructionism asserts that many "accepted" facts in a society are in fact ideas that reflect the values of the times in which they emerge.

The foregoing information may explain why the DSM classification system does not fully represent the knowledge base or values of the social work profession, which emphasizes a transactional, person-in-situation perspective on human functioning. Still, the DSM is extensively used by social workers, for many positive reasons. Worldwide, the medical profession is preeminent in setting standards for mental health practice, and social workers are extensively employed in mental health settings, where clinical diagnosis is considered necessary for selecting appropriate interventions. In fact, social workers account for more than half of the mental health workforce in the United States

(Whitaker, 2009). Competent use of the DSM is beneficial to social workers (and clients) for the following reasons:

- Social workers are employed in a variety of settings, not just mental health agencies and facilities, where they meet people who are vulnerable to mental health disorders because of poverty, minority status, and other social factors. No matter what their setting, social workers should be able to recognize the symptoms of possible disorders in their clients and appropriately refer them for treatment services.
- The five-axis diagnostic system (which considers mental disorders, developmental disorders, medical problems, environmental stressors, and a global assessment of client functioning) provides the basis of a comprehensive bio- (Axis III), psycho- (Axes I, II, and V), and social (Axis IV) assessment.
- An accurate diagnosis facilitates the development of a suitable intervention plan.
- The diagnostic categories enable social workers to help clients, and possibly also their families, learn about the nature of the client's problems. Although some stigma is often attached to the assignment of a diagnostic label, many people take a certain comfort in learning that their painful experiences can be encapsulated in a diagnosis. It validates their experience, lets them know that other people suffer from the same disorder, and offers hope that their problems can be treated.
- Use of the DSM allows practitioners from various disciplines to converse in a common language about clients.
- The DSM perspective is incorporated into professional training programs offered by a variety of human service professions and portions of state social worker licensing examinations.
- Insurance companies usually require a formal DSM diagnosis for client reimbursement.

For these many reasons, social workers need to gain competence in DSM diagnosis, and enabling them to do so is a major purpose of this book. To that end, each chapter covers a particular mental disorder and is illustrated with two to three case studies on which readers can practice their skills and knowledge. Cases have been selected to represent the diversity of people with whom social workers intervene. The disorders chosen for this book are those that social workers may see in their employment or field settings and that have sufficient research information behind them. For instance, reactive attachment disorder is not included, even though child clients may carry this diagnosis, because there has been little research on the disorder itself, despite the fact that many data have been gathered throughout the years on attachment theory and attachment styles.

We will now turn to an overview of the DSM multiaxial classification system, using the case that opened the chapter as an illustration. (We note that the next edition of the DSM may include significant changes to the classification system, possibly reducing the number of axes used [APA, 2010]). We will then describe some of the tensions involved in DSM diagnosis as practiced by social workers and discuss how this book will help develop social workers' skills in ways that will overcome some of the limitations of the DSM approach for clinical practice.

THE DSM CLASSIFICATION SYSTEM

Following is a description of the DSM five-axis classification of mental disorders, along with some general guidelines for its use (APA, 2000).

Axis I   Beginning with the problem that is most responsible for the current evaluation, the mental disorder or other condition that may be a focus of clinical attention (a V-code diagnosis) is recorded under Axis I. The

mental disorders, including adjustment disorders, will make up the chapters of this book. Although they are typically not given on their own, because they are not reimbursed by insurance, the V-codes are given in three different situations: (a) when no mental disorder is present but a problem needs clinical attention, (b) when there is a problem unrelated to the mental disorder, or (c) when a problem related to the mental disorder is sufficiently severe to warrant clinical attention of its own (APA, 2000).

When uncertain if a diagnosis is correct, the social worker should use the provisional qualifier. If a person no longer meets criteria for a disorder that may be relevant to his or her current condition, the qualifier "past history" can be given. For example, if a woman seeks help for depression while she is pregnant, it may be important to note if she had an eating disorder history.

Axis II   This axis includes the disorders that are considered to have more of a constitutional basis and includes the personality disorders and mental retardation. They are considered to represent relatively chronic conditions that can put the person at risk for a variety of Axis I disorders. If a personality disorder is the most important reason for the client's request for evaluation, the social worker should add the term *principal diagnosis*.

Axis III   This axis includes the person's general medical conditions, which may have a direct bearing on an Axis I diagnosis or may affect (or be affected by) management of an Axis I or II diagnosis. The source of the information should also be listed here, such as "according to the client" or "confirmed in the chart by a physician."

Axis IV   This axis is used to record psychosocial and environmental problems that have occurred in the last year and are a focus of clinical attention. These involve problems with the following: primary support group, economic or social environment, access to health care services, educational system, interaction with the legal or criminal systems, occupational setting, housing problems, and any other psychosocial stressors, such as phase-of-life and acculturation problems. The social worker should record the formal term and also add descriptive information about the stressor, such as "educational problem—failed past year of school."

Although Axis IV does not relate to problems within the individual, but only to environmental conditions, no differentiation is made between environmental problems that are contributing to a person's disorder (risk influences) and those that are consequences of the disorder. For example, educational problems in a child with oppositional defiant disorder (ODD) often arise because of disruptive behaviors displayed at school; it is not that the educational problems result in ODD.

Axis V   Global assessment of functioning (GAF) indicates the level of a client's social, occupational, and psychological functioning on a 100-point scale reflecting a continuum of mental health and illness. It comprises two scores: one reflecting the client's current GAF (the past week) and another reflecting the client's highest level during the past year. The DSM includes anchor descriptions for each 10 points on the scale. The reader should note that GAF scores, like many aspects of the DSM, are subject to interpretation. GAF scores tend to have low reliability, as individual clinicians vary widely in their assignment of scores.

Following is a list of "hierarchical principles" that can help the practitioner decide which diagnoses to use in situations where several might be considered:

- "Disorders due to a general medical condition" and "substance-induced disorders," which include not only substances people consume but also medications they are prescribed, preempt a diagnosis of any other disorder that could produce the same symptoms.
- The fewer diagnoses that account for the symptoms, the better. This is the rule of "parsimony." Practitioners need to understand the "power of the diagnostic label," in its negative as well as positive aspects, and use diagnostic labels judiciously. For example, posttraumatic stress disorder (PTSD) and reactive attachment disorder are sometimes diagnosed simultaneously in children. Although they share some presentation, when they are used together, the diagnostic picture becomes imprecise and does not lead to a coherent treatment plan.
- When a more pervasive disorder has essential or associated symptoms that are the defining symptoms of a less pervasive disorder, the more pervasive disorder is diagnosed if its criteria are met. For example, if "oppositional defiant disorder" and "conduct disorder" are both present, the social worker should use the "conduct disorder" diagnosis, because its range of criteria overlaps with the former diagnosis (see chapter 5 for case examples).
- When the client's presentation seems to match several diagnostic categories, the social worker should use the least severe diagnosis possible, to treat the client with respect and to avoid stigma and the negative social effects of labeling. Though there is no official ranking of diagnoses by severity, some categories do seem to be less stigmatizing than others, in that they are more common and shorter term in nature (such as an adjustment disorder versus depression, or depression versus a psychotic disorder or a personality disorder). Thus the social worker may assign a client an adjustment disorder diagnosis or a V-code (although the latter is not usually reimbursable by insurance companies).

The principles outlined earlier are, of course, applied only after a comprehensive client assessment is carried out. Each chapter in this book includes assessment principles relevant to specific disorders, but here we present some general guidelines for the assessment of a client's mental, emotional, and behavioral functioning.

MENTAL STATUS EXAMINATION

A Mental Status Examination (MSE) is a process by which a social worker or other human services professional systematically examines the quality of a client's mental functioning. Ten areas of functioning are considered individually. The results of the examination are combined with information derived from a client's social history to produce clinical impressions of the client, including a DSM diagnosis. An MSE can typically be completed in 15 minutes or less. One commonly used format for an MSE evaluates the following areas of client functioning (Daniel & Gurczynski, 2003):

- *Appearance.* The person's overall appearance in the context of his or her cultural group. These features are significant because poor personal hygiene or grooming may reflect a physical inability to care for one's physical self or a loss of interest in doing so.

- *Movement and behavior.* The person's manner of walking, posture, coordination, eye contact, and facial expressions. Problems with walking or coordination may reflect a disorder of the central nervous system.
- *Affect.* This refers to a person's outwardly observable emotional reactions and may include either a lack of emotional response or an overreaction to an event.
- *Mood.* The underlying emotional tone of the person's answers.
- *Speech.* The volume of the person's voice, the rate or speed of speech, the length of answers to questions, and the appropriateness and clarity of the answers.
- *Thought content.* Any indications in the client's words or behaviors of hallucinations, delusions, obsessions, symptoms of dissociation, or thoughts of suicide.
- *Thought process.* The logical connections between thoughts and their relevance to the conversation. Irrelevant detail, repeated words and phrases, interrupted thinking, and illogical connections between thoughts may be signs of a thought disorder.
- *Cognition.* The act or condition of knowing. The social worker assesses the person's orientation with regard to time, place, and personal identity; long- and short-term memory; ability to perform simple arithmetic (counting backward by threes or sevens); general intellectual level or fund of knowledge (identifying the last five presidents, or similar questions); ability to think abstractly (explaining a proverb); ability to name specified objects and read or write complete sentences; ability to understand and perform a task (showing the examiner how to comb one's hair or throw a ball); ability to draw a simple map or copy a design or geometrical figure; ability to distinguish between right and left.
- *Judgment.* The social worker asks the person what he or she would do about a commonsense problem, such as running out of a prescription medication.
- *Insight.* A person's ability to recognize a problem and understand its nature and severity.

Abnormal results for an MSE include any evidence of brain damage or thought disorders, a mood or affect that is clearly inappropriate to its context, thoughts of suicide, disturbed speech patterns, dissociative symptoms, and delusions or hallucinations.

> **Directions:**   Now that you have read a description of the multiaxial system, hierarchical principles, and an MSE, can you work out a multiaxial diagnosis for Henry Williams before reading ahead?

Multiaxial Diagnosis

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V:

Multiaxial Diagnosis of Mr. Williams

Axis I: 292.12 Psychotic disorder with hallucinations induced by steroids
            V61.10 Partner relational problem
Axis II: V71.09 (no diagnosis on Axis II)
Axis III: 250.01 Insulin-dependent diabetes mellitus
            225.2 Meningioma (cerebral)
            345.10 Seizure disorder
            577.1 Pancreatitis

Axis IV: Problems with primary support group (marital problems)
Axis V: GAF score: 35

Rationale for the Diagnosis

Psychotic disorder with hallucinations induced by steroids was diagnosed because the symptoms began a few days after Mr. Williams started to take the medication. Steroids can affect the limbic system, causing aggression and emotional outbursts. Although this diagnosis would have to be made by medical personnel, the social worker should be aware that the symptoms of apparent mental disorders may result from a medical condition or from medication used to treat the condition.

The specifier "with hallucinations" was used because the patient's hallucinations (casting out the demons) seemed to predominate over his delusions (thinking that his wife was cheating on him). The latter appeared to have a basis in reality, even though he was the one who had had an affair. Projection of his own behavior onto his wife may have caused the delusion. It should also be noted that Mr. Williams had just had a brain tumor removed; changes in mood and affect are fairly common in these patients. A diagnosis of psychotic disorder due to a medical condition can be excluded, however, because Mr. Williams did not show symptoms before or right after the craniotomy was performed. Instead they developed six days after the surgery. The V-code, partner relational problem, was also diagnosed due to the long-standing marital problems that have recently resurfaced due to Mr. Williams's accusations.

The GAF score of 35 was given because Mr. Williams is experiencing major symptoms, including impaired reality testing, hallucinations, and delusions, which cause him to behave aggressively and seriously impair his relationships with others. Although Mr. Williams's current GAF score is very low, there is considerable hope that he will be able to return to his previous level of functioning, because his symptoms appear to be the temporary side effects of the steroids he was given in the hospital.

LIMITATIONS OF THE DSM

Any classification of mental, emotional, and behavioral disorders is likely to be flawed, as it is difficult for any system to capture the complexity of human life. As noted earlier, the DSM classification system is based on the medical model of diagnosis, while the profession of social work is characterized by the consideration of systems and the reciprocal impact of persons and their environments on human behavior (Walsh, 2010). That is, for social workers the quality of a person's social functioning should be assessed with regard to the interplay of biological, psychological, and social factors in his or her life. Three types of person-in-environment situations likely to produce problems in social functioning include life transitions, relationship difficulties, and environmental unresponsiveness (Carter & McGoldrick, 2005). Social work interventions, therefore, may focus on the person; the environment; or, more commonly, both. Some other limitations of the DSM from the perspective of the social work profession are described on the following pages. Additionally, each chapter offers critiques of the particular DSM diagnosis and/or the medical perspective underlying it. Readers are encouraged to offer a critical perspective when presented with each of the case illustrations.

One of the criticisms of the DSM is that the reliability of diagnosis (agreement among practitioners about the same clients) is not

Diversity in Practice

Practice Behavior Example: *Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power.*

Critical Thinking Question: Consider Mr. Williams's cultural context. In what ways might his cultural context affect the way he is assessed for a diagnosis by a majority culture practitioner? Give an example of how an oversight in this regard might result in an inappropriate intervention.

high for some disorders, and generally has not risen since DSM-II (Duffy, Gillig, & Tureen, 2002). Second, psychiatric diagnoses are often based on cultural notions of normality versus abnormality and mental health versus illness (Maracek, 2006). For example, homosexuality was considered a mental disorder until 1974, when political pressure on the creators of the DSM was successfully applied (Kutchins & Kirk, 1997). Today, some question the validity of the diagnosis of gender identity disorder, claiming that it represents an unusual but valid gender orientation (Hill, Rozanski, Carfagnini, & Willoughby, 2005).

Third, arising as it does from the psychiatric profession, the DSM may overstate the case for biological influences on some mental disorders (Cooper, 2004; Healy, 2002; Johnston, 2000). For instance, heritability for both major depression and anxiety is about 30 to 40% (Hettema, Neale, & Kendler, 2001; Sullivan et al., 2000); for substance use disorders heritability is about 30% (Walters, 2002). Although other biological factors may play a role in the development of mental disorders aside from genetics (e.g., complications at birth, exposure to lead), social factors (family environment, community, social support, income levels) certainly play a large role as well.

Fourth, in a related vein, the DSM tends to view clients in isolation and decontextualizes the disorder from the person and the life circumstances that have given rise to it (Westen, 2005). Generally speaking, the DSM does not highlight the roles played by systems in the emergence of problems. Some parts of the DSM do so, however, primarily with the "adjustment disorders," in which people are seen as having difficulty adjusting to environmental stressors. Further, the V-codes allow practitioners to articulate relational issues, and Axis IV is also helpful in balancing the personal and the social aspects of life.

Fifth, some feminists argue that the DSM is gender-biased, according a higher prevalence of many disorders to women (notably depression, anxiety, and many of the personality disorders) (Wiley, 2004). The DSM has been criticized for blaming women for their responses to oppressive social conditions (Blehar, 2006).

Sixth, because not all symptoms need to be met for any diagnosis to be made, two people with the same diagnosis can have very different symptom profiles. There is also an acknowledged abundance of "subthreshold cases" (those that do not quite meet the minimum number of symptom criteria), even though these may produce as much impairment as those that meet full diagnostic criteria (Gonzalez-Tejara, Canino, & Ramirez et al., 2005). This problem of a lack of specificity has been dealt with in part by the addition over time of new subtypes of disorders, and also by the introduction of severity qualifiers (mild, medium, severe).

Due to this limitation of the DSM, many people have argued that mental disorders should be assessed through a dimensional approach on a continuum of health and disorder. (Some such changes may in fact appear in DSM-V, for example in the chapter on personality disorders [APA, 2010]). Measurement instruments assess symptoms in a dimensional context rather than through a categorical system like the DSM, in which a person either meets certain criteria or does not. In this book we may occasionally mention some measures that might be useful for assessment, but the focus is on DSM diagnosis. The interested reader is encouraged to refer to other books that focus on measurement instruments (e.g., Corcoran & Walsh, 2006; Fischer & Corcoran, 2007; Hersen, 2006).

Seventh, the problem of comorbidity, in which a person may qualify for more than one diagnosis on an axis, is a point of significant confusion among practitioners. The reader will note that, throughout this book, comorbidity rates for disorders are often substantial. The DSM encourages the recording of more than one diagnosis on an axis when the assessment justifies doing so. But many disorders (e.g., anxiety disorders and depression)

correlate strongly with one another (Kessler, Chiu, Demler, & Walters, 2005). It may be that an anxious depression differs from either a "pure" major depressive disorder or anxiety disorder in critical ways. In addition, research on treatment generally confines itself to people without comorbid disorders, so that results are often not generalizable to the treatment population at large.

Finally, the DSM makes no provisions for recording client strengths. Strengths-oriented practice implies that practitioners should assess all clients in light of their capacities, talents, competencies, possibilities, visions, values, and hopes (Guo & Tsui, 2010; Saleeby, 2008). This perspective emphasizes human *resilience*—the skills, abilities, knowledge, and insight that people accumulate over time as they struggle to surmount adversity and meet life challenges. In chapters 2 and 3, we will discuss the appraisal of strengths—both at individual and environmental levels.

PRACTICE TEST The following questions will test your knowledge of the content found within this chapter. For additional assessment, including licensing-exam type questions on applying chapter content to practice behaviors, visit **MySocialWorkLab.com**

1. Which of the five axes of the DSM diagnostic system is most consistent with the perspective of the social work profession?

   a. Axis I
   b. Axis II
   c. Axis IV
   d. Axis V

2. A major disparity between the social work perspective and the medical model of mental illness is:

   a. The medical model ignores the impact of environmental events on human functioning
   b. The medical model sees disorders as existing within the person
   c. Social work deemphasizes the role of biology in the development of mental disorders
   d. Social work prefers psychosocial to medication interventions

3. Lynda experienced a crisis during the seventh week of classes of her first semester at the university. She had been having trouble in her courses but was shocked to receive two Cs and two Ds. Her chronic sense of sadness became worse and for the first time in her life she started having thoughts of suicide. Before making a diagnosis for Lynda, the social worker should first:

   a. Interview her parents
   b. Review several of her school assignments
   c. Assess for the existence of any medical conditions
   d. Speak with her academic advisor

4. Assessment of a client's global assessment of functioning takes into account the present situation as compared to the recent past. In Lydia's situation, it is likely that:

   a. Her current score would likely be lower than that of her previous-year score
   b. Her current score would likely be higher than that of her previous-year score
   c. Her current and previous-year scores will likely be similar
   d. These cannot be assessed until she has been in treatment for one month

5. Diagnoses of medical conditions take priority over mental health diagnoses, but social workers often perform client assessments in agencies where medical practitioners are not available to assist. With what types of clients do you think a medical assessment is absolutely necessary?

6. Given that the DSM reflects a medical model of mental illness, construct an alternative diagnostic system consisting of three to five axes. Which may be more consistent with the social work person-in-environment perspective?

SUCCEED WITH