ADVANCING CORE COMPETENCIES SERIES

DSM 5

MENTAL HEALTH IN SOCIAL WORK

A Casebook on Diagnosis and Strengths Based Assessment

SECOND EDITION

Jacqueline Corcoran • Joseph M. Walsh

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CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Professional Identity	
Practice Behavior Examples…	
Serve as representatives of the profession, its mission, and its core values	3
Know the profession's history	
Commit themselves to the profession's enhancement and to their own professional conduct and growth	
Advocate for client access to the services of social work	
Practice personal reflection and self-correction to assure continual professional development	
Attend to professional roles and boundaries	12
Demonstrate professional demeanor in behavior, appearance, and communication	
Engage in career-long learning	
Use supervision and consultation	
Ethical Practice	
Practice Behavior Examples…	
Obligation to conduct themselves ethically and engage in ethical decision-making	
Know about the value base of the profession, its ethical standards, and relevant law	
Recognize and manage personal values in a way that allows professional values to guide practice	11
Make ethical decisions by applying standards of the National Association of Social Workers' Code of Ethics and, as applicable, of the International Federation of Social Workers/International Association of Schools of Social Work Ethics in Social Work, Statement of Principles	12
Tolerate ambiguity in resolving ethical conflicts	
Apply strategies of ethical reasoning to arrive at principled decisions	5
Critical Thinking	
Practice Behavior Examples…	
Know about the principles of logic, scientific inquiry, and reasoned discernment	
Use critical thinking augmented by creativity and curiosity	
Requires the synthesis and communication of relevant information	
Distinguish, appraise, and integrate multiple sources of knowledge, including research-based knowledge, and practice wisdom	4, 8, 9, 10
Analyze models of assessment, prevention, intervention, and evaluation	1
Demonstrate effective oral and written communication in working with individuals, families, groups, organizations, communities, and colleagues	6

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CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Diversity in Practice	
Practice Behavior Examples…	
Understand how diversity characterizes and shapes the human experience and is critical to the formation of identity	2
Understand the dimensions of diversity as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation	6
Appreciate that, as a consequence of difference, a person's life experiences may include oppression, poverty, marginalization, and alienation as well as privilege, power, and acclaim	8
Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power	1, 5, 7
Gain sufficient self-awareness to eliminate the influence of personal biases and values in working with diverse groups	
Recognize and communicate their understanding of the importance of difference in shaping life experiences	7, 10
View themselves as learners and engage those with whom they work as informants	
Human Rights & Justice	
Practice Behavior Examples…	
Understand that each person, regardless of position in society, has basic human rights, such as freedom, safety, privacy, an adequate standard of living, health care, and education	
Recognize the global interconnections of oppression and are knowledgeable about theories of justice and strategies to promote human and civil rights	
Incorporates social justice practices in organizations, institutions, and society to ensure that these basic human rights are distributed equitably and without prejudice	5
Understand the forms and mechanisms of oppression and discrimination	2
Advocate for human rights and social and economic justice	
Engage in practices that advance social and economic justice	
Research-Based Practice	
Practice Behavior Examples…	
Use practice experience to inform research, employ evidence-based interventions, evaluate their own practice, and use research findings to improve practice, policy, and social service delivery	1, 4
Comprehend quantitative and qualitative research and understand scientific and ethical approaches to building knowledge	
Use practice experience to inform scientific inquiry	
Use research evidence to inform practice	9

CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Human Behavior	
Practice Behavior Examples…	
Know about human behavior across the life course; the range of social systems in which people live; and the ways social systems promote or deter people in maintaining or achieving health and well-being	
Apply theories and knowledge from the liberal arts to understand biological, social, cultural, psychological, and spiritual development	2
Utilize conceptual frameworks to guide the processes of assessment, intervention, and evaluation	4, 8, 11,13
Critique and apply knowledge to understand person and environment.	4, 7, 13
Policy Practice	
Practice Behavior Examples…	
Understand that policy affects service delivery and they actively engage in policy practice	
Know the history and current structures of social policies and services; the role of policy in service delivery; and the role of practice in policy development	
Analyze, formulate, and advocate for policies that advance social well-being	7, 9
Collaborate with colleagues and clients for effective policy action	8
Practice Contexts	
Practice Behavior Examples…	
Keep informed, resourceful, and proactive in responding to evolving organizational, community, and societal contexts at all levels of practice	
Recognize that the context of practice is dynamic, and use knowledge and skill to respond proactively	
Continuously discover, appraise, and attend to changing locales, populations, scientific and technological developments, and emerging societal trends to provide relevant services	9, 11
Provide leadership in promoting sustainable changes in service delivery and practice to improve the quality of social services	10

CSWE's Core Competencies and Practice Behavior Examples in This Text

Competency	Chapter
Engage, Assess Intervene, Evaluate	
Practice Behavior Examples…	
Identify, analyze, and implement evidence-based interventions designed to achieve client goals	
Use research and technological advances	
Evaluate program outcomes and practice effectiveness	
Develop, analyze, advocate, and provide leadership for policies and services	
Promote social and economic justice	
A) ENGAGEMENT	3
Substantively and effectively prepare for action with individuals, families, groups, organizations, and communities	
Use empathy and other interpersonal skills	13
Develop a mutually agreed-on focus of work and desired outcomes	
B) ASSESSMENT	3
Collect, organize, and interpret client data	
Assess client strengths and limitations	2, 12
Develop mutually agreed-on intervention goals and objectives	5
Select appropriate intervention strategies	
C) INTERVENTION	
Initiate actions to achieve organizational goals	
Implement prevention interventions that enhance client capacities	12
Help clients resolve problems	
Negotiate, mediate, and advocate for clients	5
Facilitate transitions and endings	
D) EVALUATION	3, 6
Critically analyze, monitor, and evaluate interventions	

Second Edition

DSM-5 update

Mental Health in Social Work

A Casebook on Diagnosis and Strengths-Based Assessment

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Preface

Mental Health in Social Work: A Casebook on Diagnosis and Strengths-Based Assessment is a graduate-level textbook that will help students and professionals learn to understand clients holistically as they proceed with the assessment and intervention process. A major purpose of *Mental Health in Social Work* is to familiarize readers with the *American Psychiatric Association's Diagnostic and Statistical Manual* (DSM) classification of mental disorders. The primary reasons that social workers need to become conversant with the DSM are the following: (1) to offer clients appropriate referrals and treatment; (2) to communicate effectively with other mental health professions; and (3) to be eligible for third-party reimbursement.

The learning in Mental Health in Social Work primarily occurs through a case study method; students are asked to respond to case illustrations that are presented in each chapter. Cases (two to three in each chapter) have been selected to represent the diversity of people with whom social workers intervene. Answers to the questions posed about each case are provided in an instructor's manual and should be discussed in class and/or through feedback on case study assignments. Note that in order to complete the diagnosis in each case, readers will have to use the DSM-5.

While gaining competence in DSM diagnosis, the reader is also taught to maintain a critical perspective on the various DSM diagnoses and the medical model as promulgated through the DSM. The field of social work has a focus not just on the individual, but on the person within an environmental context, and concerns itself with strengths as well as problems. Additionally, social work has a traditional commitment to oppressed and vulnerable populations. Because the DSM is limited in these areas, *Mental Health in Social Work* includes the biopsychosocial risk and resilience perspective**,** which takes into account both risks and strengths at the individual and environmental levels. Each chapter then explores the relevant risk and protective influences for each disorder, highlighting some of the particular risks for special populations, including children, women, the elderly, minorities, people with disabilities, gay and lesbian individuals, and those from low socioeconomic strata. Students are asked to complete risk and resilience assessments for the case studies presented.

Another emphasis in *Mental Health in Social Work* is evidence-based treatment, a recent movement in social work and various other health and mental health disciplines. The meaning of evidence-based practice can be debated (Norcross, Beutler, & Levant, 2006), but has been generally defined as the prioritization of research evidence when social workers consider how to best help clients. However, client preferences and available resources must also be part of the process of clinical judgment in addition to research studies (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). In considering the hierarchy of evidence, whenever possible we rely on systematic reviews and meta-analyses, which are considered "first-line evidence" (Petticrew & Roberts, 2006). These systematic reviews aim to comprehensively locate and synthesize the treatment outcome literature in a particular area. If the review lends itself to combining the results of primary studies in a quantitative way, then it is referred to as meta-analysis (Petticrew & Roberts, 2006).

From these reviews of the literature, *Mental Health in Social Work* presents treatment guidelines for each disorder covered in the book, and through the case studies, students will learn how to form evidence-based treatment plans. At the same time, in keeping with

the importance of the environmental context, interventions address the broad nature of the concerns that people bring to social work professionals. For instance, if socioeconomic problems, such as lack of health insurance and unemployment, are part of the client's presenting problems, then intervention will appropriately address these concerns, as they are critical to a person's well-being and healthy functioning.

The Council on Social Work Education has implemented educational policy and accreditation standards that involve competencies and the practice behaviors associated with them that social workers are to learn. As a result, *Mental Health in Social Work* has become part of the *Advancing Core Competencies* series. The following table demonstrates how the competencies and practice behaviors are an integral part of this book. Additionally, each chapter includes critical thinking questions that exemplify the competences and practice behaviors.

In summary, this book takes a case study approach, with students applying evidence-based information on mental disorders to build their social work competency in terms of assessment and treatment of mental illness.

Social Work Competencies Addressed in Casebook Exercises

Competency	Practice behaviors	Casebook application
Competency 2.1.1—Identify as a professional social worker and conduct oneself accordingly	P.B. 2.1.1a: Readily identify as social work professionals P.B. 2.1.1c: Manage assessment interviews with clients, using the person-in-environment perspective	The social work perspective is balanced with the biomedical perspective of DSM with the risk and resilience biopsychosocial assessment. An overall critique of DSM is offered in chapter 1 and for each DSM disorder.
Competency 2.1.4—Engage diversity and difference in practice	P.B. 2.1.4a: Research and apply epidemiological knowledge of diverse populations and their mental/behavioral disorders	A chart for each mental disorder with a discussion of socially diverse populations.
	P.B. 2.1.4.Fa: Recognize the extent to which a culture's structures and values may oppress, marginalize, alienate, or create or enhance privilege and power	A critique of the DSM and its association with our culture's power structures is presented in chapter 1. Directions for each case study include Critical Perspective: Formulate a critique of the diagnosis as it relates to the case example. Questions to consider include the following: Does this diagnosis represent a valid mental disorder from the social work perspective? How does oppression, discrimination, and trauma play out in the development of the disorder? Your critique should be based on the values of the social work profession (which are incongruent in some ways with the medical model) and the validity of the specific diagnostic criteria applied to this case (i.e., is this diagnosis significantly different from other possible diagnoses?).
Competency 2.1.3—Apply critical thinking to inform and communicate professional judgments	P.B. 2.1.3c: Identify and articulate clients' strengths and vulnerabilities as part of the assessment	Directions for each case study include Biopsychosocial Risk and Resilience Assessment: Formulate a risk and resilience assessment, both for the onset of the disorder and for the course of the disorder, including the strengths that you see for this individual and the techniques you would use to elicit them.

Competency	Practice behaviors	Casebook application
Competency 2.1.5—Advance human rights and social and economic justice	P.B. 2.1.5a: Use knowledge of the effects of oppression, discrimination, and trauma on development of clients' mental/emotional/behavioral disorders	Directions for each case study include Critical Perspective: Formulate a critique of the diagnosis as it relates to the case example. Questions to consider include the following: Does this diagnosis represent a valid mental disorder from the social work perspective? How does oppression, discrimination, and trauma play out in the development of the disorder? Your critique should be based on the values of the social work profession (which are incongruent in some ways with the medical model) and the validity of the specific diagnostic criteria applied to this case (i.e., is this diagnosis significantly different from other possible diagnoses?).
Competency 2.1.6—Engage in research-informed practice	P.B. 2.1.6a: Use research knowledge to inform clinical assessment/diagnosis	Evidence-based assessment and practice guidelines are presented based on the latest research for each disorder.
Competency 2.1.7—Apply knowledge of human behavior and the social environment	P.B. 2.1.7a: Synthesize and differentially apply biological, developmental, social, and other theories of etiology associated with specific mental, emotional, and behavioral disorders	The latest research on etiological factors associated with mental disorders in general (chapter 2) and for each mental disorder is presented.
	P.B. 2.1.7b: Use a biopsychosocial-spiritual perspective and diagnostic classification system to formulate differential diagnoses	Directions for each case study include Diagnosis: Prepare the following: a diagnosis, the rationale for the diagnosis, and additional information you would have wanted to know in order to make a more accurate diagnosis.
	P.B. 2.1.7.Fa: Utilize conceptual frameworks to guide the processes of assessment, intervention, and evaluation.	Strengths-based assessment techniques, solution-focused therapy, and motivational interviewing are covered in chapter 2. Theories of evidence-based intervention are covered for each mental disorder.
	P.B 2.1.7b: Critique and apply knowledge to understand person and environment	Directions for each case study include Biopsychosocial Risk and Resilience Assessment: Formulate a risk and resilience assessment, both for the onset of the disorder and for the course of the disorder, including the strengths that you see for this individual and the techniques you would use to elicit them.
Competency 2.1.3—Apply critical thinking to inform and communicate professional judgments P.B. 2.1.3.b: Analyze models of assessment, prevention, intervention, and evaluation (S)	P.B. 2.1.3.a: Distinguish, appraise, and integrate multiple sources of knowledge, including research-based knowledge, and practice wisdom (S)	Directions for each case study include Goal Setting and Treatment Planning: Given your risk and resilience assessments of the individual, your knowledge of the disorder, and evidence-based practice guidelines, formulate goals and a possible treatment plan for this individual.

Competency	Practice behaviors	Casebook application
Competency 2.1.10—Assess with individuals, families, groups, organizations, and communities	P.B. 2.10.d: Collect, organize, and interpret data (P)	Directions for each case study include Diagnosis: Given the case information, prepare the following: a diagnosis, the rationale for the diagnosis, and additional information you would have wanted to know in order to make a more accurate diagnosis.
	P.B. 2.10.e: Assess client strengths and limitations (P)	Directions for each case study include Biopsychosocial Risk and Resilience Assessment: Formulate a risk and resilience assessment, both for the onset of the disorder and for the course of the disorder, including the strengths that you see for this individual and the techniques you would use to elicit them.
	P.B. 2.10.g: Select appropriate intervention strategies (P)	Directions for each case study include Goal Setting and Treatment Planning: Given your risk and resilience assessments of the individual, your knowledge of the disorder, and evidence-based practice guidelines, formulate goals and a possible treatment plan for this individual.

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Chapter 1

Diagnosis and the Social Work Profession

Henry Williams, a 59-year-old African American, 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 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 et al., 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 60 years. The latest version is *DSM-5*, published in May 2013.

The definition of *mental disorder* in DSM-5 (APA, 2013) is a "syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (p. 20). Such a disorder usually represents significant distress in social or occupational functioning. 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 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 diagnostic system provides the partial basis of a comprehensive bio-psycho-social assessment.
- An accurate diagnosis facilitates the development of a suitable intervention plan (although many interventions are available for persons with the same diagnosis).
- The diagnostic categories enable social workers to help clients, and possibly also their families, learn about the nature of the client's problems. Although 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 that is shared by others. It validates their experience 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 relatively little research on the disorder itself, despite the fact that data have been gathered throughout the years on attachment theory and attachment styles.

We now turn to an overview of the DSM classification system, using the case that opened the chapter as an illustration. We will later 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 to clinical practice.

THE DSM CLASSIFICATION SYSTEM

Following is a description of the DSM classification system of mental disorders, along with some general guidelines for its use (APA, 2013).

Beginning with the problem that is most responsible for the current evaluation, the mental disorder is recorded. Most major diagnoses also contain subtypes or specifiers (e.g., "mild," "moderate," and "severe") for added diagnostic clarity. When uncertain if a diagnosis is correct, the social worker should use the "provisional" qualifier, which means he or she may need additional time or information to be confident about the choice. It is important to recognize that more than one diagnosis can be used for a client, and medical diagnoses should also be included if they are significant to the client's overall condition. Social workers cannot make medical diagnoses, of course, but they can be included if they are noted in a client's history or the client reports their existence. Further, 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 used, although this would not be the primary diagnosis. 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. Social and environmental problems that are a focus of clinical attention may also be included as part of the diagnosis. A chapter in the DSM titled "Other Conditions That May Be a Focus of Clinical Attention" includes a list of conditions (popularly known as *V-codes*) that are not considered formal diagnoses but can be used for that descriptive purpose.

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 symptoms of both "autism spectrum disorder" and "specific communication disorder" are present, the social worker should use the former diagnosis, because its range of criteria overlaps with the latter one (see chapter 3 for case examples).

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 diagnostic system, hierarchical principles, and an MSE, can you work out a diagnosis for Henry Williams before reading ahead?

Diagnosis

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Diagnosis of Mr. Williams

292.12	Medication-induced psychotic disorder, with onset during intoxication, severe
F19.959	without use disorder
250.01	Insulin-dependent diabetes mellitus
225.2	Meningioma (cerebral)
345.10	Seizure disorder
577.1	Pancreatitis
V61.10	Relational distress with spouse

Rationale for the Diagnosis

Medication (steroid)–induced psychotic disorder was diagnosed because Mr. Williams's symptoms began a few days after he 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. A diagnosis of psychotic disorder due to a medical condition was excluded because Mr. Williams did not show symptoms before or immediately after the craniotomy was performed. They developed six days after the surgery.

The "with onset during intoxication" specifier was used because the symptoms developed after Mr. Williams began taking the medication, rather than after he terminated it (which would be a withdrawal state). The "severe" specifier indicates that the symptoms (delusions and hallucinations) are dramatic, present, and severe. (The delusions may 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. Finally, the "without use disorder" specifier indicates that Mr. Williams does not have an existing substance use disorder apart from what he is now experiencing. (We also note here that some, but not all, specifiers have numerical codes, as is true in this case.)

While four other diagnoses refer to Mr. Williams's medical condition, the final notation ("relational distress with spouse") is included to indicate that his marital situation will be a focus of the overall intervention.

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 a 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. 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. 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 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 high for some disorders, and generally has not risen significantly since DSM-II (Duffy, Gillig, & Tureen, 2002). Second, psychiatric diagnoses are often based on cultural notions of normality versus abnormality (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). Gender dysphoria was considered to be a disorder (gender identity disorder) until the publication of DSM-5. It had been classified as a sexual disorder but now occupies its own chapter in the text and the term *disorder* is no longer affixed to it.

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, Neale, & Kendler, 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.

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, such as with the "adjustment disorders," in which people are seen as having difficulty adjusting to environmental stressors. Further, social workers have the opportunity to make diagnostic

reference to personal and the social aspects of life in the diagnosis through the use of V-codes.

Fifth, some feminists argue that the DSM is gender-biased, according a much higher prevalence of many disorders to women than men (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 "sub-threshold 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 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, many people have argued that mental disorders (e.g., anxiety, depression, and personality disorders) should be assessed through a dimensional approach, on a continuum of health and disorder. Many 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. Several systems of this type are included in Part III of the DSM (e.g., with personality disorders) but they have not yet been adopted for "official" use. In this book we may occasionally mention 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 (Corcoran & Walsh, 2010; Fischer & Corcoran, 2007; Hersen, 2006).

Seventh, the problem of comorbidity, in which a person may qualify for more than one diagnosis, is a point of 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 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—at both individual and environmental levels.

References

Chapter 2

Biopsychosocial Risk and Resilience and Strengths Assessment

This book is organized with a biopsychosocial risk and resilience framework for understanding and intervening with persons who have mental disorders. In this chapter, we first describe this framework and its advantages for social work assessment. Next, we detail a number of risk and protective factors at the biological, psychological, and social levels that may contribute to or inhibit the development of mental disorders. In the last section of the chapter, we cover techniques that social workers can use to elicit and build upon strengths of individuals and their social environment, going beyond naturally occurring protective factors.

DEFINITIONS AND DESCRIPTION

Although the biological and psychological levels relate to the individual, the social aspect of the framework captures the effects of the family, the community, and the wider social culture. The processes within each level interact, prompting the occurrence of risks for emotional or mental disorders (Shirk, Talmi, & Olds, 2000) and the propensity toward resilience, or the ability to function adaptively despite stressful life circumstances. Risks can be understood as hazards occurring at the individual or environmental level that increase the likelihood of impairment developing (Bogenschneider, 1996). Protective mechanisms involve the personal, familial, community, and institutional resources that cultivate individuals' aptitudes and abilities while diminishing the possibility of problem behaviors (Dekovic, 1999). These protective influences may counterbalance or buffer against risk (Pollard, Hawkins, & Arthur, 1999; Werner, 2000) and are sometimes the converse of risk (Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1997). For instance, at the individual level, poor physical health presents risks while good health is protective. It must be noted that research on protective influences is limited compared with information on risks for various disorders (Donovan & Spence, 2000).

The biopsychosocial emphasis expands one's focus beyond the individual to a recognition of systemic factors that can both create and ameliorate problems. The nature of systems is such that the factors within and between them have transactional and reciprocal influence on one another, with early risk mechanisms setting the stage for greater vulnerability to subsequent risks. The development of oppositional defiant disorder and conduct disorder (see chapter 10) is a case in point that shows how the presence of certain risk or protective mechanisms may increase the likelihood of other risk and protective influences.

Although precise mechanisms of action are not specified, data have begun to accumulate that four or more risk influences may overwhelm an individual and represent a threat to adaptation (Epps & Jackson, 2000; Frick 2006; Garmezy, 1993; Runyan et al., 1998). Although some have found that the more risks, the worse the outcome (Appleyard, Egeland, van Dulmen, & Sroufe, 2005), others have argued that risk does not proceed in a linear, additive fashion (Greenberg, Speltz, DeKlyen, & Jones, 2001). Nor are all risk factors weighted equally. The associations between risk and protection and outcomes are complex and may involve changing conditions across a person's development.

The biopsychosocial framework holds a number of advantages for the assessment of mental disorders. It provides a theoretical basis for social workers to conceptualize human behavior at several levels and can assist them in identifying and bolstering strengths as well as reducing risks. The framework offers a balanced view of systems in considering both risks and strengths, as well as recognizing the complexity of individuals and the systems in which they are nested.

The chapters in this book delineate the risk and protective influences for both the onset of particular disorders and an individual's adjustment or recovery. Some of the influences discussed in each chapter are nonspecific to that particular disorder; in other words, certain risks and protective mechanisms play a role in multiple disorders. These common mechanisms, discussed at the individual and social levels, are good targets for intervention and prevention and are given an overview here.

INDIVIDUAL FACTORS

Individual factors encompass the biological and psychological realms. Within biology we will discuss genes, neurotransmitters, temperament, physical health, developmental stage, and intelligence. At the psychological level we will explore individual patterns of behavior.

Biological Mechanisms

Genes and heritability

Genes determine the extent of internal risk for the development of disorders (Bulik, 2004). Although information on the genetic influences of all mental disorders is not available, the disorders differ in the extent to which genetic causes are attributed to them. For instance, heritability for major depression ranges from 31 to 42% (Sullivan, Neale, & Kendler, 2000); similarly, many anxiety disorders seem to be moderately heritable. Certain other disorders, such as bipolar disorder and schizophrenia, are more heritable (U.S. Department of Health & Human Services [DHHS], 1999).

For most disorders, specific genetic markers have not been delineated, and genetic models for many disorders increasingly include a number of genes (Williams, Reardon, Murray, & Cole, 2005). Even for disorders assumed to have genetic causes, those conditions result not only from abnormalities in inherited genes but also from certain gene combinations or other errors in genes caused during pregnancy by such events as infections and exposure to x-rays (Arc, 2007). Finally, it is widely hypothesized that a genetic vulnerability may be activated by the presence of adverse environmental events (Williams et al., 2005).

Neurotransmitters

Many people describe mental disorders as caused by "chemical imbalances in the brain." Neurotransmitters are the chemicals that convey communication between neurons. These substances are naturally regulated by breaking down in the spaces between cells or through reuptake into transmitting cells. Problems with neurotransmitter action