empowerment series

FOURTH EDITION

PSYCHOPATHOLOGY

A Competency-Based Assessment Model for Social Workers

Susan W. Gray

Educational Policy (EP), 2015 Educational Policy and Accreditation Standards discussed in *Psychopathology: A Competency-Based Assessment Model for Social Workers,* 4th Edition

Competency 1 Demonstrate Ethical and Professional Behavior	
a. Social workers make ethical decisions by applying the standards of the NASW Code of Ethics and other relevant laws, regulations, and models for ethical decision-making, as appropriate to context	See chapter(s): 3, 5, 6, 7, 8, 10, 14, and 16
b. Social workers use reflection and self-regulation to manage personal values and maintain professionalism	1, 2, 3, 4, 5, 13, 15, and 16
c. Social workers demonstrate professional demeanor in behavior, appearance, and oral/written/electronic communication	2, 3, 10, 12, 13, and 16
Competency 2 Engage Diversity and Difference in Practice	
a. Social workers apply and communicate understanding of the implications of diversity and difference in shaping life experiences in practice at the micro, mezzo and macro levels	See chapter(s): 2, 3, 9, 10, 11, 13, and 14
b. Social workers present themselves as learners and engage clients (and constituencies) as experts of their own experiences	7, 12, 15, and 16
c. Social workers apply self-awareness and self-regulation to manage the influence of personal biases and values in working with diverse clients (and constituencies)	14
Competency 4 Engage in Practice-Informed Research and Research-Informed Practice	
a. Social workers use practice experience and theory to inform scientific inquiry and research	See chapter(s): 5, 6, 7, 8, and 14
c. Social workers use and translate research evidence to inform and improve practice and service delivery	8 and 14
Competency 5 Engage in Policy Practice	
a. Social workers identify social welfare and economic policies at the local, state, and federal levels impact well-being, service delivery, and access to social services	See chapter(s): 2, 7, 13, 14, 15, and 16
b. Social workers assess how social welfare and economic policies impact delivery of and access to social services	8 and 9
c. Social workers apply critical thinking to analyze, formulate, and advocate for policies that advance human rights, and social, economic, and environmental justice	2, 8, and 14

(*Continued on inside back cover*)

4th Edition

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A Competency-Based Assessment Model for Social Workers

Susan W. Gray
Barry University
Ellen Whiteside McDonnell School of Social Work

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***Psychopathology: A Competency-Based Assessment Model for Social Workers*, Fourth Edition**
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To my beloved husband,
Kenneth E. Gray, JD
… you are my inspiration.

Contents

PREFACE

INTRODUCTION

All of us engage in behaviors that we usually do not think a lot about—from eating, to talking, feeling, thinking, remembering, playing, buying things, or even going to the bathroom, to list a few. However, these behaviors can potentially have a maladaptive component that can be diagnosed as a mental disorder. These dysfunctions are a source of substantial concern to many different mental health professions whose members hold differing opinions regarding the etiology, pathology, and treatment of these disorders. Professionals think in terms of their "language," and in order to be able to meaningfully communicate with one another, it is important to share a common vocabulary. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association (APA, 2013) offers an official diagnostic nomenclature, making it a powerful document. It plays a significant role in how practitioners, their agencies, funding sources, social programs, and the general public conceptualize and respond to problematic and maladaptive behaviors (Schwartz & Wiggins, 2002).

Among the 500,000 mental health professionals in the United States who use the DSM-5, the largest group is social workers (U.S. Department of Labor, Bureau of Labor Statistics, 2010) followed by mental health counselors (American Counseling Association, 2011), psychologists (American Psychological Association, 2012), and psychiatrists (APA, 2011). Moreover, social work practice specific to the field of mental health is the largest subspecialty within the profession (Whitaker, Weismiller, Clark, & Wilson, 2006). Historically, the use of the psychiatric nomenclature in social work practice has been controversial and has generated considerable discussion within the profession (Washburn, 2013). To some extent, mental disorders are the constructions of practitioners and researchers rather than proven diseases and illnesses (Maddux, Gosselin, & Weinstead, 2008). On the other hand, the diagnoses found in the DSM are not necessarily lacking credibility or empirical support.

THE *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS* AND ITS FIFTH EDITION

The publication of the DSM-5 in 2013 is the fifth edition of the DSM, representing the first major revision to the manual in more than 30 years (APA, 2013). The DSM has a profound influence on all mental health professions. Certainly there

have been numerous controversies surrounding the DSM-5 including the overall reliability of the system, poor research for field trials, its seeming slant toward a biological approach, the relative lack of participation of professional groups other than psychiatry, and the inclusion and definition of particular mental disorders—most notably the autism spectrum (First, 2010; Frances, 2012, 2013; Friedman, 2012; Jones, 2012; Pomeroy & Anderson, 2013). Admittedly, the DSM-5 may contain flaws, but for the most part it describes what is reasonably understood by most practitioners and researchers to be the predominant forms of psychopathology. The psychiatric diagnosis is primarily a way of communicating and the categories of the different disorders can be useful without necessarily being "the final word" about how people function. The DSM-5 may be imperfect and sometimes biased, but no one has questioned whether the manual should be used at all or suggested that there is an alternative way to move forward. Regardless of the criticisms, the reality is that the DSM remains as the primary classification system across the counseling professions for diagnosis and reimbursement purposes (Washburn, 2013). If we are to provide our clients with the best possible services, then the ability to make an accurate diagnosis is an important step in that direction. Regardless of where you stand, it is essential to become familiar with the changes in the DSM-5 and its potential impact on clients. In fact, using the DSM-5 is unavoidable for many clinical social workers. For instance, the Association of Social Work Boards (ASWB) includes questions specific to the DSM on its licensing exams, which are required by almost every state (Frazer, Westhuis, Daley, & Phillips, 2009). Beginning in July 2015, the licensure test questions shifted to testing knowledge of the DSM-5.

Revising the DSM has been an enormous undertaking and no diagnostic process is perfect. Keep in mind that a work of this magnitude will have some errors. The APA has made every effort to keep up with the listing of errata, and you are encouraged to check the association's website (http://www.dsm5.org), which posts corrections to the manual. It is anticipated that minor text edits will be corrected in later publications.

In the prior edition of this book I shared the experience of one of my students on a field trip we took to an agency that works with the severely and persistently mentally ill organized around the clubhouse model. Essentially this student had reservations around working with "those people" until she met a real client and had the chance to get to know him a little better as he proudly showed us around the agency. I still remember this client's greeting as we approached the front door of the agency. He had a big smile and proudly announced, "Hi, I'm Danny and I have schizophrenia. Welcome to our clubhouse. I can't wait to show you around." I remembered thinking, who knows more about mental illness than someone who lives with a disorder on a daily basis? Danny's symptoms may wax and wane, but ultimately they do not go away. The competency-based approach to the assessment process takes into account a client's lived experiences with a diagnosis. From this perspective, Danny's diagnosis becomes but a part of his identity and does not define him. The intent of the competency-based model is to advance the assessment process to one that recognizes each person's uniqueness rather than to focus solely on a diagnostic label.

Lacasse and Gomory (2003) analyzed a sample of psychopathology syllabi from top graduate schools of social work around the country and found that the most frequently required texts were authored by psychiatrists. No course had a stand-alone

text authored by a social worker. As social workers, we are familiar with working from a strengths perspective with our clients, and this orientation somehow becomes lost in books from other disciplines. This book is written by a social worker for social workers. Learning about psychopathology and related diagnoses is like learning a new language. Best to learn this language with a social work accent!

THE BOOK'S ORGANIZATION

The changes in the DSM-5 will require practitioners to relearn how to classify and conceptualize some mental disorders. The aim of this book's fourth edition is to help readers understand the new features of the DSM-5 to the extent that you can take this information and, by incorporating the competency-based assessment model, apply diagnoses correctly. As with prior editions, case studies are provided to highlight diagnostic criteria and to differentiate among the different diagnoses.

Stigma and misunderstanding of mental illness is pervasive, and many still consider mental health problems to be the result of personal shortcomings. The book is organized around the competency-based model, which highlights the biological (including neurological), psychological, and social aspects of a person's life as a part of the diagnostic process. In this way, understanding psychopathology will not focus on character flaws or personal weakness but include a strengths-based orientation to the assessment, which looks to how someone like Danny copes with and rebounds from the challenges of living with a mental disorder. The diagnosis understands the individual's biopsychosocial makeup, cultural and political influences, coping methods, and factors that are a basis for strengths, resiliency, and resources. This orientation balances psychopathology with a parallel appreciation of factors related to strengths and resiliency. It goes without saying that using the DSM requires skill in order to be able to distinguish the client's symptom picture. The competency-based assessment extends this understanding and looks beyond a review of the client's symptoms to consider how a disorder is experienced, how it is expressed, and how symptoms are interpreted by the person and those close to him or her.

INTRODUCTION TO ENHANCED CONTENT

You will find a number of changes in each of the chapters. The DSM-5 definition of mental illness takes into account the neurological features of mental disorders. In order to familiarize the social work practitioner with the neurological contributions to psychopathology, Chapter 1 expands the review of the biopsychosocial framework supporting the competency-based assessment by including content on the role of the brain and related systems in psychopathology. Subsequent chapters include a discussion of these influences around particular disorders. A review of changes to the reorganization of the DSM are also included.

The DSM-5 classification system cuts across all developmental stages, thus eliminating the need for a separate chapter on the disorders of infancy, childhood, and adolescence as seen in the DSM-IV-TR. From a life-span perspective, disorders specific to early development are placed in the second chapter on neurodevelopmental disorders, and a later chapter on neurocognitive disorders addresses late life

developments. This approach to DSM reorganization also attempts to better reflect the relative strength of relationships among disorder groups. For example, although there is an overlap of symptoms among the anxiety disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and acute stress disorder, each has a different clinical presentation and are now included in separate chapters on the basis of overt symptoms in the DSM-5. However, clients with any one of these closely related disorders can show comorbid disorders from among this spectrum (Bienvenu et al., 2011).

Consistent with this approach to the DSM classification system, new chapters have been added; for example, obsessive-compulsive and related disorders, and trauma- and stressor-related disorders, to list a few. To remain consistent with prior editions, all of the chapters from 2 through 16 in the book have been ordered around how they appear in the DSM. You will find a review of the specific disorders followed by an updated discussion of prevailing patterns, and the differential diagnosis. Case vignettes are presented followed by a diagnosis and the competency-based assessment. An assessment summary reviews possible alternative diagnoses so that readers can become familiar with the process of distinguishing symptoms and client competencies in reality-based situations. In this way, readers may learn to take the client's "whole person" into account when making a diagnosis of mental illness. Not every disorder addressed in the DSM-5 appears in the book. The intent is to provide a more in-depth review of those syndromes social workers will more than likely encounter in their everyday practice. As before, each chapter is designed to stand alone. This feature was kept in order to facilitate individual instructor preference around sequencing the teaching of content about a particular disorder. In addition, it is easier for readers who might want to re-review a diagnosis.

New case stories have been added throughout the book to illustrate the new diagnoses included in the DSM-5. For example, you will notice the case of John Laughlin highlighting disruptive mood dysregulation disorder in the depressive disorders chapter, and Larry Dalton's experiences with gambling disorder in the substance-related and addictive disorders chapter. There are numerous familiar case studies from prior editions, but the diagnosis has been updated to reflect the DSM-5 diagnostic criteria. For example, Rudy Rosen still struggles with schizophrenia, but the way it has been diagnosed is different. To add context to the diagnostic shifts, each chapter ends with a summary of the changes from the DSM-IV-TR to the DSM-5. Sometimes a diagnosis that the practitioner will more than likely not see in the average practice situation was reviewed, and this was done to expand the overall understanding of the diagnostic categories in the DSM-5. For instance, you will find Patty Nemeth's story about separation anxiety in the chapter featuring the anxiety disorders, and Mary Ellen Creamer's struggles with pica in the feeding and eating disorders chapter. The DSM-5 has moved away from a categorical approach to the diagnosis—that is, either you meet criteria for a diagnosis or not—and more toward a dimensional perspective. Reflective of this shift, you will find more listings of diagnostic specifiers and severity ratings for each of the diagnoses.

The fourth edition of the book remains a part of the Cengage Learning Empowerment Series and continues to integrate the Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards (EPAS). However, in March 2015, CSWE approved a new set of standards, referred to as practice competencies. This newly revised set of practice behaviors has been integrated into each

chapter, thus further supporting the book's emphasis on a performance-based orientation to learning that links theory and action; that is, using real-life case examples to highlight the assessment process. Competency notes are provided at the end of each chapter that describe each competence and its relationship to chapter content. The Appendix contains test questions for each chapter, and they have been expanded to reflect the revisions to this edition.

While the book targets social workers, it can be used by all mental health professionals taking courses in psychopathology, human behavior, or direct practice. It is also a good reference for practitioners who want to review the basics of psychopathology or to prepare for a licensure exam. Supervisors will find it a useful reference for psychiatric diagnoses. The case studies are drawn from real-life practice experiences, and I hope readers will find the diversity reflective of contemporary practice. All case stories have been changed to protect anonymity, and some represent a compendium of different client experiences. Any resemblance to a real-life client is accidental and not intentional. The cases can be used by both instructors and supervisors as a part of a homework assignment, to supplement lectures, or adapted to provide evidence of students' understanding of the assessment process in practice.

INSTRUCTOR SUPPLEMENTS

For this edition of the textbook, the author has crafted a detailed Instructor's Manual to support your use of the new edition. The manual includes chapter summaries, practitioner reflections that can be used as student exercises, suggestions for further study, and additional online and print resources. There is also a detailed test bank and a set of classroom PowerPoint slides that accompany the text.

This material can be found at http://www.cengagebrain.com.

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The DSM-5 created the opportunity for making significant changes in the book. It did not take very long for me to realize that an undertaking like this could be accomplished only with a lot of help and support. I would especially like to acknowledge all of the helping hands behind the scenes who worked diligently to make this edition of the book a reality. Looking back, I find it hard to believe that 15 years have passed since the first edition was published. Back then I could not have predicted that the competency-based assessment would make such an enduring contribution to the mental health field. I am always collecting case stories—from my own practice, students, supervisees, and colleagues—and continue to be impressed by the strength and resilience of those who struggle with a mental disorder. Thank you to all who have shared their "stories" with me.

Diagnosing clients is not an easy task. The DSM-5 provided an exciting opportunity to look at this process through the lens of the values of our profession and then applying those values in contemporary practice. Over and over again, readers have shared that this textbook, with its real-life case stories, has helped them to learn psychopathology in a way that keeps in mind the uniqueness of each person who struggles with the challenges associated with living with a mental disorder.

Thank you for encouraging me to continue this work. When each client's diagnosis is individualized through the competency-based assessment, we move in the direction of a societal culture that encourages a change in the negative perceptions of mental illness and the stigma that surrounds those who seek help for these challenges.

I would like to thank Gordon Lee, Product Manager–Anthropology and Social Work, who was involved at the outset, and Julie Martinez, Product Manager–Counseling, Human Services, and Social Work, who saw this edition through to its successful completion. I would also like to acknowledge those who assisted with the production phase of the book, including Tanya Nigh, Senior Content Project Manager, Jeffrey Hahn, J. L. Hahn Consulting Group, and Valarmathy Munuswamy, Associate Program Manager, Lumina Datamatics, Inc. I know there are many others on the Cengage team and I do want to acknowledge their contributions.

As a last step, I wish to thank my husband, Kenneth, whose support has made all of this possible. As with his experiences with my work on prior editions, there were many times we would miss meals, eat take out, or have lunch at 3:00 or 4:00 p.m. because I was on the computer and, "just need another minute to finish this thought." He claims not to know anything about social work but somehow manages to provide the right words of encouragement at the right time. His faith in me is something special!

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About the Author

Photography by Mazrk Safra

Susan W. Gray is Professor Emerita at Barry University's Ellen Whiteside McDonnell School of Social Work in Miami Shores, Florida. She received her PhD in social work from Barry University with a specialization in licensure and professional regulation, her EdD concentrating on adult education from Nova Southeastern University, her MBA from Barry University, and her MSW in clinical practice from Rutgers–the State University. She is a member of the National Association of Social Workers, the Academy of Certified Social Workers, and the Council on Social Work Education. She has been a member of the faculty since 1980, teaching a variety of courses across the curriculum, including foundation and advanced clinical social work practice courses specializing in working with individuals, families and groups, an elective course in crisis intervention, and a doctoral course in social work education. Among her accomplishments, Dr. Gray directed the Doctoral Program and spearheaded an extensive revision of its curriculum.

Dr. Gray is a Licensed Clinical Social Worker and registered clinical supervisor in Florida, where she also serves as a member of the Probable Cause Panel for the state licensure board. Dr. Gray holds a wide range of experience in direct clinical practice with individuals, families, and groups, having worked in a variety of clinical and community settings, including a half-way house for pregnant adolescents, family and children outpatient counseling centers, acute care medical settings, inpatient psychiatric units, and private practice. She also served as a member of the Florida Board of Clinical Social Work, Mental Health Counseling, and Marriage and Family Therapy.

Her practice interests include her work in supervision, professional regulation and licensure, rural practice, bereavement groups, intergenerational family assessment tools, the brief solution-focused model of practice, methods of classroom teaching, and aspects of cultural diversity. Dr. Gray's current research interests are in mental health assessment and practice. She has authored numerous publications, given presentations at local, state, national, and international social work conferences, and is also the author of *Competency-based Assessments in Mental Health Practice: Cases and Practical Applications*. Dr. Gray is known to be an informative and engaging speaker and has received numerous awards; most notably, she was honored as a mentor by the Council on Social Work Education's Council on the Role and Status of Women in Social Work Education and received the lifetime achievement award

from the Florida Miami–Dade National Association of Social Workers. Dr. Gray's decision to become a teacher was based on her wish to continue to serve and to pay forward all of the mentoring and support she received throughout her professional career. Looking to the new generation of graduating social workers and experienced practicing social workers, she hopes that this book will set the stage for readers to find their way to positively influence the profession beginning each client, and one case at a time.

CHAPTER 1

An Introduction to the Competency-Based Assessment Model

INTRODUCTION

The now century-old tradition of psychiatric social work was one of several specializations, including medical social work and child welfare, that emerged during the early part of the twentieth century. While the field of psychiatric social work grew during the 1900s, social workers struggled when seeking employment because of negative professional attitudes directed toward them. French (1940) identified some of the problems associated with early psychiatric social work positions such as large caseloads, low pay, and in some cases requirements to live on the institution's premises and perform nonprofessional duties within the institution.

The profession changed over time, and in the last part of the twentieth century, social workers could be found serving all areas of the public and private mental health sectors. During the past five decades, social workers have had considerable flexibility in assessing clients, with the choice of using diagnostic categories found in various editions of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) (5th ed., *APA*, 2013 [*DSM-5*]) or other psychosocial or behavioral criteria. Looking at practice in the twenty-first century, some of the ways social workers have historically assessed clients is in jeopardy, especially regarding specific diagnostic descriptions and interventions based on presenting symptoms. In an effort to make the profession a convincing competitor in the marketplace, accountability is one of the central themes for present-day contemporary social work practice. The DSM classification system is often used to meet these accountability requirements and for third-party payments. As a consequence, social workers are called upon to

balance the profession's traditional focus on client strengths and resilience with the symptom-based orientation organizing the DSM.

Looking to the future, changes in the service delivery structure of agencies, significant cost containment efforts, and the federal health care reforms enacted in 2010 have moved the profession toward a further reevaluation of the assessment process in clinical social work practice. The push toward reform of the private health insurance market, and to provide better coverage for those with preexisting conditions has set the stage for questions about spiraling medical expenses emerging in the form of increased costs for employee insurance coverage, as well as care for the poor and uninsured who currently seek medical treatment at emergency rooms and public clinics. The full extent of the repercussions of the overhaul of the American health care system are yet to be determined. Nonetheless, the implications of these initiatives are the merging of public and private services; the shifting of financial risk to service providers; the development of community-based service alternatives; and an increased emphasis on client strengths and social supports. Organized around theoretical underpinnings familiar to our profession, this book is about a competency-based assessment model that keeps sight of the complexities of life in vulnerable populations such as the mentally ill while formulating a differential diagnosis using the classification system found in the DSM.

Mental disorders are common, and in any given year, about 26.2 percent of American adults over age 18 suffer from a mental disorder (National Institute of Mental Health [NIMH], 2010). Looking to the rates of mental illness in children, approximately 7 percent of a preschool pediatric sample were given a psychiatric diagnosis in one study and approximately 10 percent of 1- and 2-year-olds receiving developmental screening were assessed as having significant emotional/behavioral problems (Carter, Briggs-Gowan, & Davis, 2004). Despite one's career direction within the field of social work, practitioners in today's practice arena are more than likely to encounter clients with mental illness. Those who work with individuals considered mentally ill recognize the need to learn how to decipher the DSM format. Part of the problem in using the manual is that one might come away from it questioning how the diagnostic criteria presented translate to the real-life clients and their struggles seen in practice. Social workers must know not only how to assess individuals effectively but also how to develop an appropriate intervention plan that addresses clients' needs.

The DSM format is not for amateurs and should not be considered a substitute for professional training in assessment or the other skills needed to work with clients. For example, tasks such as performing mental status exams and monitoring of medication (historically the sole domain of psychiatrists) are now routinely handled by social workers. It is important to recognize that using a classification system can never replace an assessment that considers "the basic fact that people are quintessentially social beings, existing with each other in symbiotic as well as parasitic relationships" (Gitterman & Germain, 2008a, p. 41). That is, the person is much more than his or her diagnosis. There have been a number of long-standing criticisms of the DSM (see e.g., Dumont, 1987; Kirk & Kutchins, 1994; Kirk, Siporin, & Kutchins, 1989; Kutchins & Kirk, 1987). Being a social work practitioner as well as an educator, my primary reason for writing this book is to help make the DSM format more understandable and accessible to other social workers. This book

does not take a linear or traditional psychiatric approach; rather, it incorporates a competency-based assessment as a vehicle to support the profession's historical orientation to practice.

Developing a working knowledge of psychopathology is similar to mastering a foreign language; at first everything seems confusing, but gradually the language becomes understandable. Similarly, beginning social work students are often anxious when asked to formulate an initial diagnosis, feeling they are somehow perpetuating the tendency to pigeonhole, stereotype, or label people. The process is complicated because most textbooks about mental disorders are written by psychiatrists or psychologists and tend to be biased toward their authors' own professional alliances. I recognize that using the DSM-5 format has been a controversial topic within social work practice (e.g., see Frances, 2012; Frances, 2013; Friedman, 2012). Since the first introduction of the manual in the early 1950s, it has been used to describe and classify mental disorders. Admittedly, the DSM is an imperfect system, and it has the potential to stigmatize clients through labeling. However, despite its drawbacks, the DSM continues to serve as the standard for evaluation and diagnosis. The aim in writing this book is not to reinvent the proverbial wheel by creating a "wannabe" mini-DSM. Rather, my concern for social work practitioners is the emphasis that the DSM places on "disease" and "illness" obscures our profession's orientation, which centers on client strengths. While practicing from a strengths perspective, the social work practitioner does not ignore the hardships people living with a particular diagnosis must face. Schizophrenia, for example, presents some very real challenges. However, the competency-based assessment model expands the focus of the evaluation to include looking at a person's abilities, talents, possibilities, hopes, and competencies. Saleebey (2012) points out that people learn something valuable about themselves when they struggle with difficulty as they move through life. Although this book is organized around the DSM, I hope to simplify the language of psychopathology in a way that will help to influence the kinds of information gathered, how it is organized, and how it is interpreted. This interpretation includes looking at those strengths that would be useful to the person who struggles with mental illness and helps the social worker focus on the resourcefulness of a person, which is a beginning step in restoring hope. In essence, the social worker looks at how people survive and cope with a diagnosis of mental illness (Gitterman, 2014). A person's resourcefulness, strengths, and coping become a part of the assessment process, ensuring that the diagnosis does not become the center of his or her identity. The "whole story" of a person must include the parts of his or her struggle that have been useful to them and the positive information they have yielded.

Competency 7 b

The competency-based assessment includes the ability to differentially apply knowledge of human behavior (specifically bio-psycho-social-spiritual theories) to better understand the client's current functioning. Familiarity with the DSM diagnostic classification system is considered to be a part of this comprehensive approach to the assessment process. **Competency-based practice** emphasizes the importance of identifying client competencies, and it focuses on assets instead of deficits. More precisely, it strives to build and enhance the client's own skills as they attempt to deal with life conditions.

The mental disorders found in the DSM will be presented here from a social work perspective. Sometimes interesting historical information will be included; at

other times editorial asides about exploration and assessment will be offered. In most cases, a clinical case vignette is presented to help the reader keep in mind the major features of assessment. Above all, the intent is to provide what social workers need in a format that will prove clinically relevant, understandable, and practitioner-friendly.

This book is not intended to address all of the specific DSM classifications, nor does it include all specific disorders. It is anticipated that assessment criteria will be advanced from a social work perspective while balancing the tensions inherent in the medical model. The competency-based assessment encompasses an ecological approach, the strengths perspective, and systems theory to determine what biopsychosocial factors contribute to the client's problems, as well as factors that may be useful in intervention planning. The struggle is to shift the lens away from defining pathology and toward focusing on internal processes in which all of the social and environmental factors that influence functioning are considered. Many current textbooks are starting to move away from terminology describing those considered mentally ill as "patients." The DSM format has also moved away from such negative descriptions. The ultimate challenge is to know how and when the DSM is effective and useful—and how and when to keep its classification system in perspective.

Competency 7 b

We now turn to a review of the DSM-5. This discussion is intended to update, and in some cases reintroduce the reader to the core concepts of the diagnostic assessment using the DSM-5.

THE DSM-5: APPROACHES TO THE ASSESSMENT

In December 2012, the American Psychiatric Association (APA) Board of Trustees voted to approve the new DSM-5. This much-anticipated revision has been received with both excitement and uncertainty. The manual was introduced at the APA's national conference in May 2013, and copies were made available to the public shortly thereafter. This latest version of the DSM represents the first major revision in nearly 20 years since the initial publication of the fourth edition (DSM-IV) in 1994. Unlike earlier editions, there was an unprecedented openness and transparency never before seen in the manual's revision process. Specifically, the APA published three separate drafts of the manual during 2012 on their website asking for feedback. This resulted in approximately 13,000 comments and thousands of emails and letters. National Institute of Mental Health (NIMH) director Thomas R. Insel, MD, wrote in an April 29, 2013, blog post (Insel, 2013): "The goal of this new manual, as with all previous editions, is to provide a common language for describing pathology. While DSM has been described as a 'Bible' for the field, it is, at best, a dictionary, creating a set of labels and defining each. The strength of each of the editions of DSM has been 'reliability'—each edition has ensured that clinicians use the same terms in the same ways."

Why has the DSM taken on such a large role in mental health practice? It may be related to the reality that the prevalence of mental disorders touches most people's lives or someone we know. Mental disorders are common in the United States. The Centers for Disease Control and Prevention (CDC) report, "Mental Illness

Surveillance among Adults in the United States," released on September 2, 2011, indicates that nearly 50 percent of U.S. adults will develop at least one mental illness during their lifetime (CDC, 2011). Fortunately, only about 5.8 percent of the U.S. population, or 1 in 17 adults, struggles with a severe mental disorder (NIMH, 2010). Considered as the "gold standard," the DSM establishes the almost universal measure by which medical professionals diagnose and ultimately treat mental disorders, making it an essential part of the field of psychiatry. In addition, the DSM is used by clinicians in the field of mental health, and also by researchers and health insurance companies. As well, the DSM's criteria for specific disorders is used to determine insurance coverage, grant funding, and new mental health policies. Even so, the final published edition of the DSM-5 was welcomed with both praise and challenge from mental health professionals.

As a response to criticism of the DSM-5, the DSM-5 task force chair, David Kupfer, MD, identified the conceptual framework that guided the development of the manual (Kupfer, 2013):

- Chapters of the specific disorders have been revised to signal how disorders may relate to each other based on underlying vulnerabilities or symptom characteristics.
- The specific disorders are framed in the context of age, gender, and cultural explanations in addition to being organized along a developmental life span within each chapter.
- Key disorders were combined (or reorganized) because the relationships among the different categories placed them along a single continuum, such as (the newly introduced) substance use disorder and autism spectrum disorder.
- A new section of the manual introduces emerging measures, models, and cultural guidance to help clinicians in their evaluation of patients. For the first time, self-assessment tools are included in the manual with the intent to directly include patients in their diagnosis and care.

There is also a greater alignment with the ICD-11. The number 11 represents the most recent version of the **International Classification of Diseases (ICD)**, which is a coding system used to classify morbidity data from inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys. The NCHS serves as the **World Health Organization (WHO)** Collaborating Center for the Family of International Classifications for North America. In this capacity, the center is responsible for coordination of all official disease classification activities in the United States relating to the ICD and its use. The manual attempts to harmonize with the ICD-11, which is expected to be released sometime in 2015. The DSM-5 also places a greater reliance on the genetic and neurobiological research that support a biologic etiology of many psychiatric disorders; for example, schizophrenia, autism spectrum, or depressive disorders. The biological aspects are a good fit with the competency-based assessment, which looks at the range of factors affecting a client, including biological influences.

Consistent with previous editions of the manual, using the revised DSM underscores the need for clinical training and practice experience in order to accurately distinguish between normal reactions to things that can happen in a person's life and those responses that can be diagnosed as a mental disorder. Many of the

changes in the DSM-5 will now require even experienced practitioners to relearn how to classify and conceptualize a number of disorders. These revisions support the focus of this edition of the book, which is intended to demystify what can be a complex and intimidating process to diagnose clients. You will notice a number of additional cases, which are intended to feature the diagnoses that are new to the DSM-5. Cases in the earlier editions of our book have been slightly modified to highlight the revised diagnostic process.

We now turn to the DSM-5 definition of a mental illness to set the stage for a more detailed review of how to use the DSM-5.

The DSM-5 Definition of Mental Illness

A long-standing challenge in the field of mental health practice has been making the distinction between what is a mental disorder and what can be regarded as a normal behavior. The DSM-5 proposed some changes to the definition of mental illness in an attempt to provide a more scientifically valid and clinically useful definition (Stein et al., 2010). According to the *DSM-5* (*APA*, 2013, p. 20), the following elements are required in order to diagnose mental illness:

> A mental disorder 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. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.

Using this definition, the practitioner approaches the assessment by looking for a behavioral or psychological syndrome or pattern that reflects an underlying psychobiological dysfunction. Mental illness is considered when the consequences of these conditions cause the person clinically significant distress or disability that is not an expectable response to common stressors and losses, a culturally sanctioned response to a particular event, or a result of social deviance or conflicts with society. Disorders are seen as a spectrum that can be scored in terms of severity rather than discrete categories. The rationale for moving in this direction is based on research that suggests the underlying biology of mental disorders is more dimensional than categorical (Kupfer & Regier, 2011). The guiding principles organizing the DSM-5 take into account the neurological and dimensional features of mental disorders.

Earlier versions of the DSM were organized around a categorical approach. For instance, if someone had four of nine symptoms of major depression, they did not meet the threshold for a diagnosis. In contrast, if five of nine symptoms were evident, then the person met criteria for a diagnosis of major depression. For all intents and purposes, the categorical approach is seen as an all-or-nothing approach to making a diagnosis. While a person must still meet criteria for a particular

diagnosis, the dimensional perspective on assessment takes into consideration the complexity of a particular condition through the use of specifiers, subtypes, severity ratings, and cross-cutting symptom measures when formulating a diagnosis that otherwise might be restricted by the categorical approach.

Although ultimately the diagnosis is still dependent on the practitioner's "yes or no" decision around meeting diagnostic criteria, the dimensional perspective is rooted in data-based observation. However, the DSM-5 cautions the practitioner to avoid over-quantifying a specific behavior in order to push it to a higher level of severity or to assign an additional diagnosis. The challenge for the practitioner is to determine what is central to supporting a particular diagnosis and which symptoms are situation dependent.

We now turn to a more detailed review of the manual.

How the DSM-5 Is Organized

The DSM-5 is organized into three sections (Table 1.1). Section I provides instructions on how to use the manual. This introductory section also describes the process of the manual's revision, including the field trials, the public and professional review process, and expert review. It clearly states its goal to "harmonize" with the ICD systems and shares the organizational structures—such as the dimensional approach to diagnosis, developmental and life-span considerations, the focus on culture and gender issues, and the use of other specified and unspecified diagnoses. These latter categories replace the DSM-IV diagnostic categories of "not otherwise specified" (or NOS) and allows the practitioner to specify the reason that criteria for a specific disorder are not met or the option to forgo specification.

Section II delineates the categorical diagnoses including other conditions that may be a focus of clinical attention with a new organizational structure that eliminates the former DSM-IV multiaxial system. The multiaxial system was removed in an attempt to remove artificial distinctions between medical and mental disorders. Instead, this section is organized around a life span and developmental progression intended to demonstrate how disorders relate to one another. Throughout, the disorders are framed according to age, gender, and developmental characteristics.

Section III provides assessment measures including self-assessment tools, a cultural formulation for understanding the cultural context of mental illness, a dimensional alternative for the personality disorders, and conditions suggested for further research.

Table 1.1 Summary of the Three Major Sections of the DSM-5

Section:	Focus:
Section I	Introduction and information on how to use to use the manual
Section II	Information around the categorical diagnoses
Section III	Assessment measures, cultural formulation, alternative model for the personality disorders, conditions for further study

A Closer Look at Section II

There are 20 chapters in Section II of the DSM-5 that describe specific disorder categories. Each disorder consists of three major components: the diagnostic classification, the diagnostic criteria sets, and the descriptive text. When considering a particular diagnosis, it is helpful to review the descriptive text, which further elaborates diagnostic criteria. While the descriptive text that follows each disorder varies slightly, it is generally explained under the following headings:

- Specifiers—Provide the option to define subgroupings that share features within a particular disorder.
- Recording procedures—Addresses specific coding requirements for the diagnosis.
- Diagnostic features—Elaborates the specific diagnostic criteria.
- Associated features supporting diagnosis—Considers additional features that can be seen in a particular diagnosis.
- Prevalence—Describes the occurrence of the disorder.
- Development and course—Addresses signs to look for when considering a disorder and its duration.
- Risk and prognostic factors—Addresses the environment, genetic, physiological, and other factors associated with a particular disorder.
- Culture-related diagnostic issues—Elaborates cultural influences to better inform the practitioner how a client's symptoms can be influenced by culture, race, ethnicity, religion, or geographic origin.
- Gender-related diagnostic issues—Reviews potential gender differences in the expression of the symptoms of a disorder.
- Functional consequences (of a specific disorder)—Describes specific behaviors related to a person's level of functioning.
- Diagnostic markers—Explains key indicators to look for when making the assessment.
- Differential diagnosis—Differentiates the diagnosis from other syndromes.
- Comorbidity—Describes other potential co-occurring disorders.
- Relationship to other classifications—Discusses other classification systems; for example, the ICD-11.

The chapters are organized developmentally, or as they become apparent across the life span. The first chapter introduces those diagnoses thought to reveal themselves early in life, such as the neurodevelopmental disorders, followed by the schizophrenia spectrum and other psychotic disorders. Subsequent chapters list those syndromes more commonly seen in adolescence and early adulthood (i.e., the bipolar, depressive, and anxiety disorders) and ends with those diagnoses applicable to middle and late adulthood (Kupfer, Kuhl, & Regier, 2009). Paris (2013) observes that in some cases, a person may have several diagnoses (often referred to as comorbidity) in his or her lifetime; that is, another diagnosis might be added, changed, or even deleted. Organizing the Section II chapters around developmental considerations helps the practitioner to explain to his or her clients why multiple diagnoses have been assigned or other diagnoses may have been added or changed over time (APA, 2013).

The developmental or life span approach is also evident within specific chapters. For example, the disorders that were first diagnosed in childhood listed in the DSM-IV as a separate chapter are now incorporated into the discussion of the anxiety, depressive, bipolar, trauma-related, schizophrenia, and eating disorders. In addition, the DSM-5 provides a review of specific diagnostic criteria and specifiers that relate to onset in childhood.

The DSM-5 also considers disorders clustered around what is termed internalizing and externalizing factors. The **internalizing disorders** are characterized by high levels of negative activity and are represented by prominent symptoms of anxiety, depressive, and somatic symptoms. These disorders include the depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, trauma and stressor-related disorders, and dissociative disorders.

The group of **externalizing disorders** are characterized by symptoms of prominent antisocial behaviors, disruptive conduct, substance use and impulsive behaviors. They include, for example, the disruptive, impulse-control, and conduct disorders, and the substance-related and addictive disorders. The bipolar and related disorders are considered an intermediary position and listed between schizophrenia (and other psychotic disorders) and the emotional or internalizing disorders.

Using the DSM-5

The DSM-5 has eliminated the multiaxial system found in earlier versions of the DSM. To sort through the diagnostic process, the practitioner first lists the person's reason for the visit or the principal diagnosis. For example, the book features the case of Janet Sellar to illustrate the substance-related disorders—and she has several diagnoses. However, alcohol intoxication brought Janet to the practitioner's attention, so that diagnosis is listed first. In most cases, the practitioner adds the qualifying phrase, "principal diagnosis" or "reason for visit." In situations where several conditions may have equally contributed to a client's need for care, the principal diagnosis is listed first and the remaining disorders recorded in the order of attention and treatment.

When there is not enough data to support a formal diagnosis, a provisional diagnosis may be assigned and designated by placing the term "provisional" after the apparent diagnosis. In this way, the practitioner can follow-up to determine if criteria are fully met. The provisional diagnosis is generally used for a syndrome that is typically time dependent, such as schizophrenia spectrum and other psychotic disorders. For example, the active phase symptoms for schizophrenia and other psychotic disorders must last for at least 1 month; but if the practitioner does not have specific information about the duration of a person's active phase symptoms, then the diagnosis of "schizophrenia, provisional" would be assigned.

In situations where full criteria are not met, the practitioner considers whether the symptom picture meets criteria for the "other specified" or "unspecified" classifications. The book describes the case of Chris Oghee, who was suspected of having an avoidant personality disorder in addition to alcohol use. However, at the time the diagnosis was made, the social worker had not been able to distinguish all of the symptoms, so "unspecified personality disorder" was assigned. Personality