SECTION I

UTILIZING THE *DSM-5*: ASSESSMENT, PLANNING, AND PRACTICE STRATEGY

CHAPTER 1 Getting Started

INTRODUCTION

This chapter introduces the concepts and current application principles relating psychopathology to clinical mental health practice. This application is supported through the use and explication of diagnosis-assessment skills found in today's behavioral-based biopsychosocial field of practice. The major diagnostic assessment schemes utilized in the profession, along with support and resistance issues, are introduced. Diagnosis and assessment are applied to current mental health practice. A historical perspective is explored, and the type of diagnostic assessment most utilized today is outlined. Practice strategy is highlighted, and considerations for future exploration and refinement are noted.

BEGINNING THE PROCESS

The concept of formulating and completing a diagnostic assessment is embedded in the history and practice of the clinical mental health counseling strategy. Sadler (2002) defined the traditional purpose of the psychiatric diagnosis as providing efficient and effective communication among professionals, facilitating empirical research in psychopathology, and assisting in the formulation of the appropriate treatment strategy for the client to be served. The importance of the diagnostic assessment is supported by estimates related to the prevalence of mental disorders in our population and the effects it can have on human function and productivity. It is estimated that each year, a quarter of Americans are suffering from a clinical mental disorder. Of this group, nearly half are diagnosed with two or more disorders (Kessler, Chiu, Demler, & Walters, 2005). Paula Caplan (2012), a clinical and research psychologist, wrote in the *Washington Post* that about half of all Americans can expect to get a psychiatric diagnosis in their lifetime. Although on the surface these numbers may seem alarming, some researchers question whether these incidences of mental disorders are simply a product of our times and related primarily to the taxonomy used to define a mental disorder (Ahn & Kim, 2008). In practice, this rich tradition related to making the diagnostic impression has been clearly emphasized by compelling demands to address practice reimbursement (Braun & Cox, 2005; Davis & Meier, 2001; Kielbasa, Pomerantz, Krohn, & Sullivan, 2004; Sadler, 2002). For example, whether a client has health insurance can be a factor in whether he or she gets a mental health diagnosis and the supporting treatment received (Pomerantz & Segrist, 2006). Also, use of the *DSM* and creating a psychiatric diagnosis continue to go basically unregulated and open to professional interpretation (Caplan, 2012).

To facilitate making the diagnostic impression, numerous types of diagnosis and assessment measurements are currently available—many of which are structured into unique categories and classification schemes. All mental health professionals need to be familiar with the texts often

referred to by those in the field as the bibles of mental health treatment. These resources, representing the most prominent methods of diagnosis and assessment, are the ones that are most commonly used and accepted in health service delivery. Although it is beyond our scope to describe the details and applications of all of these different tools and the criteria for each of the mental disorders described, familiarity with those most commonly utilized is essential. Furthermore, this book takes the practicing professional beyond assessment by presenting the most current methods used to support the diagnostic assessment and introducing interventions based on current practice wisdom, focusing on the latest evidence-based interventions utilized in the field.

MAKING THE DIAGNOSTIC ASSESSMENT: TOOLS THAT FACILITATE THE ASSESSMENT PROCESS

Few professionals would debate that the most commonly used and accepted sources of diagnostic criteria are the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (*DSM-5*) and the *International Classification of Diseases, Tenth Edition* (*ICD-10*) or the *International Classification of Diseases* (*ICD-11*). Across the continents, especially in the United States, these books are considered reflective of the official nomenclature designed to better understand mental health phenomena and are used in most health-related facilities. The *DSM-5* (American Psychiatric Association [APA], 2013) is the most current version of the *Diagnostic and Statistical Manual of the American Psychiatric Association* (APA), which replaced the *DSM-IV-TR* (APA, 2000).

Today, the *DSM* has similarities to the criteria listed in the *ICD* in terms of diagnostic codes and the billing categories; however, this was not always the case. In the late 1980s, it was not unusual to hear complaints from other clinicians related to having to use the *ICD* for clarity in billing while referring to the *DSM* for clarity of the diagnostic criteria. Psychiatrists, psychologists, social workers, and mental health technicians often complained about the lack of clarity and uniformity of criteria in both of these texts. Therefore, it comes as no surprise that later versions of these texts responded to the professional dissatisfaction over the disparity between the two texts, as well as the clarity of the diagnostic criteria. To facilitate practice utility, the *DSM-5,* like its previous versions, serves as a crosswalk between the two books, utilizing the criteria from the *DSM* to facilitate forming the diagnostic impression and utilizing the *ICD* for billing. Balancing the use of these two books is essential in formulating a comprehensive diagnostic assessment. Use of these two books, clearly relating them to each other with their closely related criteria and descriptive classification systems, crosses all theoretical orientations.

Historically, most practitioners are knowledgeable about both books, but the *DSM* is often the focus and has gained the greatest popularity in the United States, making it the resource tool most often used by psychiatrists, psychologists, psychiatric nurses, social workers, and other mental health professionals.

ROLE OF SOCIAL WORKERS AND OTHER MENTAL HEALTH PROFESSIONALS

The publisher of the *DSM* is the American Psychiatric Association, a professional organization in the field of psychiatry. Nevertheless, individuals who are not psychiatrists buy and use the majority of copies. Early in the introductory pages of the book, the authors remind the reader that the book is designed to be utilized by professionals in all areas of mental health,

including psychiatrists, physicians, psychiatric nurses, psychologists, social workers, and other mental health professionals (APA, 2013). Since there is a need for a system that accurately identifies and classifies biopsychosocial symptoms and for using this classification scheme as a basis for assessing mental health problems, it is no surprise that this book continues to maintain its popularity.

Of the documented 650,500 jobs held by social workers in the United States, more than 57% are in the area of health, mental health, substance abuse, medical social work, and public health, where many are directly involved in the diagnostic process (Bureau of Labor Statistics, U.S. Department of Labor, 2012). When compared with psychiatrists, psychologists, and psychiatric nurses, social workers are the largest group of mental health providers with a significant effect on diagnostic impressions related to the current and continued mental health of all clients served.

Mental health practitioners (also referred to as clinicians), such as social workers, are active in clinical assessment and intervention planning. Back as far as 1988, Kutchins and Kirk reported that when they surveyed clinical social workers in the area of mental health, the *DSM* was the publication used most often. Furthermore, since all states in the United States and the District of Columbia require some form of licensing, certification, or registration to engage in professional practice as a social worker (Bureau of Labor Statistics, U.S. Department of Labor, 2012), a thorough knowledge of the *DSM* is considered essential for competent clinical practice.

Because all professionals working in the area of mental health need to be capable of service reimbursement and to be proficient in diagnostic assessment and treatment planning, it is not surprising that the majority of mental health professionals support the use of this manual (Dziegielewski, 2013; Dziegielewski, Johnson, & Webb, 2002). Nevertheless, historically some professionals such as Carlton (1989), a social worker, questioned this choice. Carlton believed that all health and mental health intervention needed to go beyond the traditional bounds of simply diagnosing a client's mental health condition. From this perspective, social, situational, and environmental factors were considered key ingredients for addressing client problems. To remain consistent with the person-in-situation stance, utilizing the *DSM* as the path of least resistance might lead to a largely successful fight—yet would it win the war? Carlton, along with other professionals of his time, feared that the battle was being fought on the wrong battlefield and advocated a more comprehensive system of reimbursement that took into account environmental aspects. Questions raised include: How is the *DSM* used? Is it actually used to direct clinical interventions in clinical practice? Or is the focus and use of the manual primarily limited to ensuring third-party reimbursements, qualifying for agency service, or avoiding a diagnostic label? Psychiatrists and psychologists also questioned how the *DSM* serves clients in terms of clinical utility (First & Westen, 2007; Hoffer, 2008). Concerns evolved that clients were not always given diagnoses based on diagnostic criteria and that the diagnostic labels assigned were connected to unrelated factors, such as individual clinical judgment or simply to secure reimbursement. These concerns related directly to professional misconduct caused ethical and legal dilemmas that affected billable and nonbillable conditions that had intended and unintended consequences for clients. To complicate the situation further, to provide the most relevant and affordable services, many health care insurers require a diagnostic code. This can be problematic, from a social work perspective, when the assistance needed to improve mental health functioning may rest primarily in providing family support or working to increase support systems within the environment. The *DSM* is primarily

descriptive, with little if any attempt to look at underlying causes (Sommers-Flanagan & Sommers-Flanagan, 2007).

Therefore, some mental health professionals are pressured to pick the most severe diagnosis so their clients could qualify for agency services or insurance reimbursement. This is further complicated by just the opposite trend, assigning the least severe diagnosis to avoid stigmatizing and labeling (Feisthamel & Schwartz, 2009). According to Braun and Cox (2005), serious ethical violations can be included, such as asking a client to collude with the assigning of mental disorders diagnosis for services. A client agreeing to this type of practice may be completely unaware of the long-term consequences this misdiagnosis can have regarding present, continued, and future employment, as well as health, mental health, life, and other insurance services or premiums.

Regardless of the reasoning or intent, erroneous diagnoses can harm the clients we serve as well as the professionals who serve them (Feisthamel & Schwartz, 2009). How can professionals be trusted, if this type of behavior is engaged in? It is easy to see how such practices can raise issues related to the ethical and legal aspects that come with intentional misdiagnosing. These practices violate various aspects of the principles of ethical practice in the mental health profession.

Although use of the *DSM* is clearly evident in mental health practice, some professionals continue to question whether it is being utilized properly. For some, such as social workers, the controversy over using this system for diagnostic assessments remains. Regardless of the controversy in mental health practice and application, the continued popularity of the *DSM* makes it the most frequently used publication in the field of mental health. One consistent theme in using this manual with which most professionals agree is that no single diagnostic system is completely acceptable to all. Some skepticism and questioning of the appropriateness of the function of the *DSM* is useful. This, along with recognizing and questioning the changes and the updates needed, makes the *DSM* a vibrant and emerging document reflective of the times. One point most professionals can agree on is that an accurate, well-defined, and relevant diagnostic label needs to reach beyond ensuring service reimbursement. Knowledge of how to properly use the manual is needed. In addition, to discourage abuse, there must also be knowledge, concern, and continued professional debate about the appropriateness and the utility of certain diagnostic categories.

DEVELOPMENT OF THE *DSM* CLASSIFICATION SYSTEM: HISTORY AND RESERVATIONS

The *DSM* was originally published in 1952, with the most recent version, the *DSM-5,* published in 2013. The publications of the *DSM* correspond to the publications of the *ICD,* with an uncertain time frame for the next version of the *DSM,* which will accompany the adopting of the *ICD-11* published by the World Health Organization.

DSM-I *and* DSM-II

The *ICD* is credited as the first official international classification system for mental disorders, with its first edition published in 1948. The APA published the first edition of the *DSM* in 1952. This edition was an attempt to blend the psychological with the biological and provide the practitioner with a unified approach known as the psychobiological point of view. This first version of the *DSM* outlined 60 mental disorders (APA, 1952). In its spiral-bound format, it captured the attention of the mental health community. After the popularity of this first edition, the second edition of the book was published in 1968. Unlike its predecessor, the *DSM-II* did not

reflect a particular point of view; it attempted to frame the diagnostic categories in a more scientific way. Both *DSM-I* and *DSM-II,* however, were criticized by many for being unscientific and for increasing the potential for negative labeling of the clients being served (Eysenck, Wakefield, & Friedman, 1983). The mind-set at the time centered on understanding the mental health of individuals based on clinical interpretation and judgment. From this perspective, symbolic and professional meaningful interpretations of symptoms were highlighted. This perspective relied heavily on clinical interpretation while taking into account the client's personal history, total personality, and life experiences (Mayes & Horwitz, 2005). With their focus on the etiological causations for identified mental disorders, these earliest editions were often criticized for the variance in the clinical and diagnostic interpretation within the categories. The fear of individual interpretation leading to a biased psychiatric label that could potentially harm clients made many professionals cautious. The situation was further complicated by the different mental health professionals who were using this book as a diagnostic tool. Originally designed by psychiatrists, for psychiatrists, the related disciplines in mental health soon also began using the book to assist in the diagnostic process. These other disciplines, as well as some psychiatrists, warned of the dangers of using guides such as the *DSM,* arguing that the differences inherent in the basic philosophies of mental health practitioners could lead to interpretation problems. For example, Carlton (1984) and Dziegielewski (2013) felt that social workers, major providers of mental health services, differed in purpose and philosophical orientation from psychiatrists. Since psychiatry is a medical specialty, the focus of its work would be pathology-based linking with the traditional medical model, a perspective very different from social work, a field whose strengths-based perspective historically has focused on how to help clients manage their lives effectively under conditions of physical or mental illness and disability. (See Quick Reference 1.1 for a brief history of the *DSM.*)

DSM-III *and* DSM-III-R

According to Carlton (1984):

> Any diagnostic scheme must be relevant to the practice of the professionals who develop and use it. That is, the diagnosis must direct practitioners' interventions. If it does not do so, the diagnosis is irrelevant. *DSM-III*, despite the contributions of one of its editors, who is a social worker, remains essentially a psychiatric manual. How then can it direct social work interventions? (p. 85)

These professional disagreements in professional orientation continued, with further divisions developing between psychiatrists and psychoanalysts on how to best categorize the symptoms of a mental disorder while taking into account the professional's theoretical orientations. Some professionals, particularly psychiatrists, argued that there was insufficient evidence that major mental disorders were caused by primarily psychological forces; other psychiatrists, especially those skilled in psychotherapy, and other mental health professionals refused to exclude experience and other etiological concepts rooted in psychoanalytic theory (Mayes & Horwitz, 2005).

Other professionals argued that the criteria for normalcy and pathology were biased and that sex-role stereotypes were embedded in the classification and categories of the mental disorders. They believed that women were being victimized by the alleged masculine bias of the system (Boggs et al., 2005; Braun & Cox, 2005; Kaplan, 1983a, 1983b; Kass, Spitzer, & Williams, 1983;

QUICK REFERENCE 1.1

BRIEF HISTORY OF THE *DSM*

- *DSM-I* was first published by the American Psychiatric Association (APA) in 1952 and reflected a psychobiological point of view.
- *DSM-II* (1968) did not reflect a particular point of view. Many professionals criticized both *DSM-I* and *DSM-II* for being unscientific and for encouraging negative labeling.
- *DSM-III* (1980) claimed to be unbiased and more scientific. Many of the earlier problems still persisted, but they were overshadowed by an increasing demand for use of *DSM-III* diagnoses to to qualify for reimbursement from private insurance companies or from government programs. *DSM-III* is often referred to as the first edition that utilized a categorical approach and in previous research studies was often considered the model for comparison.
- *DSM-III-R* (1987) utilized data from field trials that the developers claimed validated the system on scientific grounds. Nevertheless, serious questions were raised about its diagnostic reliability, possible misuse, potential for misdiagnosis, and ethical considerations.
- *DSM-IV* (1994) sought to dispel earlier criticisms of the *DSM*. It included additional cultural information, diagnostic tests, and lab findings and was based on 500 clinical field trials.
- *DSM-IV-TR* (2000) did not change the diagnostic codes or criteria from the *DSM-IV;* however, it supplemented the diagnostic categories with additional information based on research studies and field trials completed in each area.
- *DSM-5* (2013) presented major changes in diagnostic criteria and highlighted a shift toward a dimensional approach over the previous categorical one.

Williams & Spitzer, 1983). The biggest argument in this area came from the contention that research conducted on the *DSM-III* (1980) was less biased and more scientific.

To address these growing concerns, the *DSM-III* (APA, 1980) was noted as being highly innovative. In this edition, a multiaxial system of diagnosis was introduced, specific and explicit criteria sets were included for almost all of the diagnoses, and a substantially expanded text discussion was included to assist with formalizing the diagnostic impression (Spitzer, Williams, & Skodol, 1980). This edition clearly emphasized the importance of using criteria sets based in observational and empirically based research, disregarding underlying psychic mechanisms and causes (Helzer et al., 2008). This edition was considered an improvement over the earlier versions (Bernstein, 2011); however, even this shift from a psychodynamic perspective to the medical model failed to differentiate between classification of healthy and sick individuals (Mayes & Horwitz, 2005). Therefore, many professionals believed that the earlier problems persisted and that observation data and precise definitions were not really possible, as these criteria generally were not grounded in evidence-based practice principles. However, these concerns about application were overshadowed by an increasing demand for use of the *DSM-III* for clients to qualify for participation and reimbursement from insurance companies and

governmental programs and for the treatment requirements for managed care delivery systems and pharmaceutical companies.

The APA was challenged to address this issue by an immediate call for independent researchers to critically evaluate the diagnostic categories and test their reliability. The developers initiated a call of their own, seeking research that would support a new and improved revision of this edition of the manual, the *DSM-III-R* (APA, 1987). Some professionals who had originally challenged the foundations of this edition felt that this immediate designation for a revised manual circumvented attempts for independent research by aborting the process and making the proposed revision attempt obsolete. Therefore, all the complaints about the lack of reliability concerning the *DSM-III* became moot because all attention shifted to the revision.

The resulting revision, the *DSM-III-R* (1987), did not end the controversy. This edition did, however, start the emphasis on reporting the results of field trials sponsored by the National Institute of Mental Health (NIMH). According to Mayes and Horwitz (2005), these field trials included information from more than 12,000 patients and more than 500 psychiatrists from across the country. These researchers were familiar with the *DSM-II* and had actually participated in its preliminary drafts. Pleased to see the focus on research-based criteria, critics were still concerned that those who did the criteria verification were the same individuals who supported the narrowly defined set of criteria originally identified as the disorder symptoms (Mayes & Horwitz, 2005). Others felt strongly this was a positive step toward using field trials and evidence-based research, which would allow better statistical assessment of incidence and prevalence rates of mental disorders in the general population (Kraemer, Shrout, & Rubio-Stipec, 2007).

Despite these criticisms, *DSM-III* started the trend that was followed in later versions. It outlined a common language for all mental health providers to use and to define mental disorders for professionals using the book, as well as for the systems in which it was to be utilized in the delivery of mental health services for all parties (Mayes & Horwitz, 2005).

The data gathered from these field trials helped to validate the system on scientific grounds while also raising serious questions about its diagnostic reliability, clinical misuse, potential for misdiagnosis, and ethics of its use (Dumont, 1987; Kutchins & Kirk, 1986; Mayes & Horwitz, 2005). Researchers, such as Kutchins and Kirk (1993), also noted that the new edition (*DSM-III-R*) preserved the same structure and all of the innovations of the *DSM-III,* yet there were many changes in specific diagnoses, resulting in more than 100 categories altered, dropped, or added. The complaint noted that no one would ever know whether the changes improved or detracted from diagnostic reliability when comparing the new manual with the old. Attempts to follow up on the original complaints and concerns about the actual testing of overall reliability of the *DSM-III* were not addressed, even after it was published. Specifically, Kutchins and Kirk (1997) continued to question whether these new revised versions still created an environment where diagnosis might be unnecessary or overapplied. Some researchers believe that these complaints may have evolved from a misunderstanding or misapplication of the statistical component of the *DSM* and how it related to the clinical decision making that was to result (Kraemer, Shrout, & Rubio-Stipec, 2007).

DSM-IV

Less than 1 year after the publication of the *DSM-III-R,* the APA initiated the next revision. The *DSM-IV* was originally scheduled for publication in 1990, and the expectation was that it would carry a strong emphasis on the changes that

occurred, grounded by empirical evidence. In addition to the *DSM-IV* itself, a four-volume *DSM-IV* sourcebook provided a comprehensive reference work that supported the research and clinical decisions made by the work groups and the task force responsible for updating the *DSM*. This publication included the results of more than 150 literature reviews, as well as reports outlining the data analysis and reanalysis and reports from the field trials. The four volumes of the sourcebook were the culmination of final decisions made by the task and work groups, presenting the rationale in an executive summary (APA, 1995). Because of this emphasis on evidence-based diagnostic categories and the resulting criteria, publication of *DSM-IV* was delayed until May 1994. The time period waiting its publication (1990–1994) caused some professionals to question whether this publication delay would detract attention and efforts toward substantiating earlier versions of the manual. They felt that more was needed than simply waiting for this newer version of the *DSM*, and this lack of attention could have the same disruptive impact in regard to the manual's overall reliability (Zimmerman, 1988). Most professionals agreed that the *DSM-IV* (1994) did indeed place greater emphasis on empirical evidence as a basis to amend diagnostic rules. The short time period between *DSM-III* and *DSM-III-R* and the subsequent revisions, the paucity of relevant studies, and the lack of a coherent plan to involve statistical consultation in the process limited the feasibility and impact of statistical input (Kraemer, Shrout, & Rubio-Stipec, 2007, p. 259). The *DSM-IV* was hailed for its great improvements, but whether the research-based changes were really enough to address the shortfalls identified was questioned.

DSM-IV-TR: *Another Text Revision*

The *DSM-IV-TR* (the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, text revision) was published by the American Psychiatric Association in 2000. The *DSM-IV* was published before it had more than 400 mental diagnoses, and the actual number of diagnoses did not change with the revision to *DSM-IV-TR*. The *DSM-IV* and *DSM-IV-TR* clearly had come a long way from the original volume (*DSM-I*) with its 60 diagnostic categories. To prepare for the publication of the *DSM-IV-TR,* with the work starting in 1997, the work and assignments for the task groups for this version, referred to as a text revision, were assigned. Since the *DSM* has historically been used as an educational tool, it was felt that updating this version with the most recent research was essential. The APA originally expected *DSM-5* to be published in 2005, and, with delay after delay, the eventual publication in 2013 left a big gap needing updated information. Surprisingly, even though during this period there was much new research and information, the *DSM-IV* was still considered to be relatively up-to-date, and the text revision did little to update the actual diagnostic criteria. (See Quick Reference 1.2, Reasons for the Publication of the *DSM-IV* and the *DSM-IV-TR*, and Quick Reference 1.3, Intent of the *DSM-IV-TR*.)

There were five primary reasons for releasing the *DSM-IV-TR*.

1. The authors corrected factual errors that cropped up in the *DSM-IV*. For example, there was a diagnosis termed Pervasive Developmental Disorder Not Otherwise Specified, and under this category an error was corrected that had allowed the diagnosis to be given in cases in which there was a pervasive impairment in only one developmental area rather than multiple related areas (APA, 2000). Other areas in which factual inconsistencies were corrected

QUICK REFERENCE 1.2

Reasons for the Publication of the *DSM-IV* and the *DSM-IV-TR*

1. Corrected factual errors.
2. Allowed the work study groups to review each diagnostic category to ensure that information was timely and updated.
3. Incorporated new information from literature reviews and research studies.
4. Enhanced the educational value of the book.
5. Incorporated the updated coding changes from *ICD-10 (ICD-10-CM)*, which at the time was believed to be implemented in 2004.

included Personality Change Due to a General Medical Condition and Bipolar Disorders with Melancholic Features. Comorbidity information related to a disorder was also an important addition in the *DSM-IV-TR* that clearly provided the basis for the more comprehensive diagnostic supporting information provided in *DSM-5*.

2. The authors updated the information in the *DSM-IV* with the latest supporting documentation. Better examples of the different types of behavior were added under a category outlined in this version called Autistic Disorder. Similar data were added to many of the diagnostic categories in an attempt to assist practitioners in forming a more accurate diagnostic impression.
3. At the time the *DSM-IV* was published in 1994, some of the field trials and literature reviews were still under way. The *DSM-IV-TR* included the latest research results from the period between 1994 and 2000 and integrated how this information related to the clinical diagnostic category. The majority of the categories and information from the *DSM-IV,* however, remained up-to-date without modification.
4. Since the *DSM* is often used in educational settings to teach professionals about diagnostic categories, more information was added to support this use.

QUICK REFERENCE 1.3

Intent of the *DSM-IV-TR*

According to the American Psychiatric Association, the intent of this revision was:

- To review existing information posted in the *DSM-IV* and ensure that information was up-to-date for the period and included the latest research and supporting information available.
- To make educational improvements that enhanced the value of the *DSM* as a teaching tool and included in the text the new *ICD-9-CM* codes (as many of these codes did not become available until 1996—the year after the publication of the *DSM-IV*).

5. Not all the *ICD* codes were available until 1996. Thus, those who bought early copies of the *DSM-IV* did not receive the complete *ICD* coding. Later printings included the *ICD* update. It is easy to check whether the *ICD* codes are included in the *DSM-IV* of the book by simply looking at the front cover. If the coding update is included, the cover should have a round orange stamp stating "Updated with *ICD-9-CM* Codes." The *DSM-IV-TR* incorporated the *ICD-9-CM* codes into the text.

In summary, in formulating the text revisions, none of the categories, diagnostic codes, or criteria from the *DSM-IV* changed. What was updated, however, was the supplemental information for many of the categories listed. In addition, more information was provided on many of the field trials introduced in the *DSM-IV* that were not yet completed by the original 1995 publication date. Publishing the *DSM-IV-TR* allowed the inclusion of updated research findings. Furthermore, special attention was paid to updating the sections in terms of diagnostic findings, cultural information, and other information to clarify the diagnostic categories (APA, 2000). Yet with all these changes, Muller (2008) still warned that special caution was needed, regardless of the pronounced efforts to make the *DSM* more research based. Muller clearly outlined the dangers of taking the reports of patients with abnormal thoughts, feelings, and behaviors and stretching them to fit the symptoms related to one or more checklists.

DSM-5—*Long Awaited: Change and Controversy*

Although Chapter 2 discusses the application of the latest version of the *DSM-5* in greater detail, a brief summary of the controversy and changes related to the *DSM-5* is provided here. Similar to previous versions, the American Psychiatric Association continues to develop the *DSM* to reflect clinical approaches to diagnosis and training. Furthermore, similar to its history, the *DSM* continues to strive to be compatible with (but not identical to) the issues presented in the International Classification of Diseases (*ICD-10*) and, to be preemptive, also includes the codes for the *ICD-11* scheduled to be published in 2017.

Prior to the publication of this latest version, *DSM-5,* criticism remained strong. Debates were extensive about what changes needed to occur. Hoffer (2008) encouraged inclusion of additional supportive information, such as medical and diagnostic tests, that could better clarify the diagnoses identified. Sadler, Fulford, and Phil (2004) requested a more comprehensive approach that would take into account the perspective of patients and their families to support both sound policy and public concerns. Shannon and Heckman (2007) warned about the continued danger of being too quick to "pathologize" behaviors and label them. In the midst of this discussion related to the expected changes, Zachar and Kendler (2007) stated it was probably best to just accept that mental disorders are highly complicated concepts that need to be determined. From this perspective, it becomes possible to accept that some aspects of this mental disorder taxonomy will need to be determined (as opposed to discovered) with practical goals and concerns at the forefront of the diagnostic assessment (Ahn & Kim, 2008). Last were the concerns written in open letters to the APA discussing the long-term hazards that can occur when highlighting neurobiology as the standard basis for treatment, while de-emphasizing sociocultural variations and how they can affect the completion of a comprehensive diagnostic impression.

To support this controversy, Caplan (2012) warned that just having the word *statistical* in the title could give professionals and the lay public

alike a false sense of hope that the professionals who used the book could do so with scientific precision. Because making a mental health diagnosis remains an unregulated diagnostic category, significant differences in professional acumen and judgment would continue. These differences could easily result in differential diagnostic criteria in research and clinical practice and, similar to previous versions of the *DSM,* could affect problem awareness, knowledge, reporting, and subsequent generalizability of the clinical diagnostic assessments made. Bernstein (2011) questioned how the *DSM-5* work groups would recognize the importance of facilitating communication across what could be considered "restrictive diagnostic silos" (p. 29). Yet she remained optimistic that this could be addressed at least to some degree by recognizing the clusters of symptoms that might best characterize what a client is feeling.

Listening carefully to these concerns, the American Psychiatric Association made some significant changes in the *DSM-5* to both form and content. Consistent with the professional call for modification, to start this process, major changes were made to the structure and the format of the book, resulting in all chapters being organized in the life span order. For example, within this new organizational structure, the mental disorders that can occur in infants, children and adolescents are now listed first in each chapter. This led to the elimination of the Child Disorders section outlined in *DSM-IV* and *DSM-IV-TR*.

Also, relative to Bernstein's (2011) request for clustering of symptoms, crosscutting was introduced, where symptoms relative to a closely related disorder could be taken into account without formulating a new diagnostic condition. In addition, the introduction of the dimensional approach may also help with firming up the diagnosis. This change was one of the revision's most active debates, as it directly surrounded extending the categorical approach to a more dimensional approach (Helzer et al., 2008). The work groups for *DSM-5* hope that the dimensional approach will allow greater flexibility and recognition that mental disorders cannot be easily described by a single diagnostic category (Helzer et al., 2008). Dimensional assessments also appear to permit the practitioner to assess the severity of the symptoms in a particular client while crosscutting or taking into account symptoms relative to a number of different diagnoses that can influence current presentation and behavior. The following chapters of this book will explain many of these pronounced changes in greater detail.

Despite much controversy, the newest edition of the *DSM* was unveiled at the APA conference at the end of May 2013 and has been restructured and divided into three sections (see Quick Reference 1.4). These proposed revisions within the *DSM-5* were supported by a task force of more than 160 world-renowned

QUICK REFERENCE 1.4

***DSM-5* Three Sections**

- Section I: Introduction and Directions on How to Use the Updated Manual
- Section II: Outline of the Categorical Diagnoses That Eliminate the Multi-Axial System (20 Disorder Chapters and Two Additional Supporting Information Categories)
- Section III: Conditions That Require Future Research, Cultural Formulations, and Other Information

QUICK REFERENCE 1.5

CATEGORICAL SECTIONS: 20 DISORDERS AND TWO ADDITIONAL CATEGORIES

***DSM-5* Chapters**	
Neurodevelopmental Disorders	Gender Dysphoria
Schizophrenia Spectrum and the Other Psychotic Disorders	Disruptive, Impulse Control, and Conduct Disorders
Bipolar and the Related Disorders	Substance-Related and Addictive Disorders
Depressive Disorders	Neurocognitive Disorders
Anxiety Disorders	Personality Disorders
Obsessive-Compulsive and the Related Disorders	Paraphilic Disorders
Trauma and Stressor-Related Disorders	Other Mental Disorders
Dissociative Disorders	*Medication-Induced Movement Disorders and Other Adverse Effects of Medication
Somatic Symptom Disorders	*Other Conditions That May Be a Focus of Clinical Attention
Feeding and Eating Disorders	*Includes other conditions and problems that require clinical attention but are not considered mental disorders.
Elimination Disorders	*Not considered mental disorders.
Sleep-Wake Disorders	
Sexual Dysfunctions	

practitioners and researchers who were selected members of 13 work groups. These work groups reviewed the research literature, consulted with a number of experts, and for the first time sought public comment. Section One provides an introduction to the manual, some rationale for the changes, and instructions on how to use the updated manual. It is followed by 21 chapters that outline the documented mental disorders found in Section Two (see Quick Reference 1.5). The last section of the manual, Section Three, outlines the conditions that require future research, cultural formulations, and other information.

DIAGNOSTIC LABELS

Regardless of the controversy surrounding the use of the earlier, current, or future versions of the *DSM* as a diagnostic assessment tool, such tools continue to be used. One of the biggest concerns remains: Categorizing an individual with a mental health diagnosis can result in a psychiatric label that is difficult to remove. Many practitioners believe that they must always consider the implications of making the diagnosis. When used properly, the identification of disorders and the acquisition and reimbursement of delivered services results. Consequences that are not intended can lead to social stigma and loss of other opportunities (Caplan, 2012; Moses, 2009). There is no question that labeling an individual with a mental health diagnosis can result in personal and public stigma (Hinshaw & Stier, 2008). In fact, some mental health professionals feel so strongly about labeling clients that they continue to resist using this assessment scheme in their practices. For example (as is discussed later in this text), if a child is given

the diagnosis of conduct disorder in youth, many professionals believe that this condition will continue into adulthood, resulting in the classification of a lifelong mental health condition known as antisocial personality disorder. What complicates this diagnosing pattern further is that clients who receive such a diagnosis may start acting that way, creating a negative feedback loop that leads the individual to act in accordance with the condition given (Tsou, 2007).

Such a label, whether accurate or inaccurate, can be very damaging to the client because of the negative connotations that characterize it and because of what then becomes expected of the client for himself or herself and others. The negative connotations that sometimes accompany the diagnostic label of conduct disorder (e.g., generally unresponsive to intervention, lack of moral standards, and lack of guilt) may result in conduct-disordered behaviors that may not have been present to begin with (e.g., severe aggression toward people or animals). These types of behaviors are unacceptable by all societal standards, yet if legitimized as part of a diagnosis, the effect can be twofold: If in conduct disorder it is expected that the client has no control over the behaviors exhibited, these overt actions may be viewed as acceptable or unchangeable. When unacceptable behaviors are considered an inevitable part of the diagnosis, there may be less hope for the individual's capacity for growth and change. Also, if the condition is not present but the individual was incorrectly classified with the diagnosis of conduct disorder, the client may begin to develop behaviors viewed as unacceptable and unchangeable, thus acting in accordance with the diagnosis. Regardless, these behaviors are accepted or tolerated because they are related to a mental disorder. (See Quick Reference 1.6 for a list of some Positive Aspects (pros) and Negative Aspects (cons) of the *DSM*-5.)

One common misconception that remains true about each edition of the *DSM* diagnostic scheme is that "the classification of mental disorders classifies people, when actually what are being classified are the disorders that people have" (APA, 2000, p. xxxi). Professionals must be sensitive to the labels placed and utilized when referring to people who have a mental health disorder. For example, never refer to an individual as "a schizophrenic" but rather as "an individual with schizophrenia" or "an individual who suffers from schizophrenia." Consideration should always be used to ensure that terms are not used incorrectly and that individuals who have a mental disorder are not referred to or

QUICK REFERENCE 1.6

DSM-5: Positive Aspects (PRO) and Negative Aspects (CON)

PRO: Leads to uniform and improved diagnosis.

CON: Leads to diagnostic labels.

PRO: Improves informed professional communication through uniformity.

CON: Can provide limited information on the relationship between environmental considerations and aspects of the mental health condition.

PRO: Provides the basis for a comprehensive diagnostic and educational tool.

CON: Does not describe intervention strategy.

treated in a careless or derogatory manner. It is important to guard against this type of labeling and to remind others to do so as well.

When mental health assessment schemes are utilized, a diagnostic label is placed on the client. In the ideal situation, labels would not exist, nor would treatment for certain mental health conditions be more likely than others to be reimbursed. Often in health and mental health practice, much of the assessment and diagnosis process is completed based on service reimbursement needs. Many health care professionals feel the pressure and focus on more reimbursable diagnostic categories, although there can be serious consequences for these pressures. For mental health practitioners, careful evaluation of what is actually happening with the client is essential. The diagnostic assessment starts with providing an accurate diagnosis (despite reimbursements as a criterion and incentive to diagnose). In this process, care is taken to prepare the client for the stigma that can occur with trying to overcome a diagnostic label with negative connotations or a label for which reimbursement is typically not allowed.

ANOTHER MENTAL HEALTH ASSESSMENT MEASURE

Social workers believe strongly in design and base all practice strategy on the recognition of the person in the environment or person in the situation (Colby & Dziegielewski, 2010; Dziegielewski, 2013). From this perspective, the individual is believed to be part of the social environment, and his or her actions cannot be separated from this system. The individual is influenced by environmental factors in a reciprocal manner.

Impetus toward the development of this perspective may be partially related to dissatisfaction with the reliance on psychiatric-based typologies, which failed to account for environmental influences. The categorical approaches within the *DSM* did not appear to give such influences proper attention. Because these existing categories did not involve psychosocial situations or units larger than the individual within a system, problems were not viewed from an environmental context, thereby increasing the probability of such problems being classified as a mental illness (Braun & Cox, 2005). In such a system, mental health practitioners could diagnose an individual with a mental health condition due to some general medical or symptom-based concern but were given no leeway to address a mental health condition based on life events and/or situational factors.

What transpired with the dynamic changes starting in the *DSM-III* encouraged social workers and other mental health professionals to provide aggregate parts to a diagnostic classification system. This focus on the individual tended to minimize the psychological and social causation, focusing more strongly on the reductive and biological causations of the disorders, hence its specific focus on symptom-based typologies (Brendel, 2001). Clear demarcation of symptom-based criteria for diagnosing and classification encouraged by insurance companies became an efficient and cost-effective measure for the treatment of mental disorders. Because insurance companies required a medical diagnosis before service reimbursement, social workers, psychologists, and other mental health professionals waged a long and difficult fight to use *DSM* independently for third-party payment purposes and their distinct services.

Originally developed through an award given to the California chapter of the National Association of Social Workers (NASW) from the NASW Program Advancement Fund (Whiting, 1996), a system was designed to focus on psychosocial aspects, situations, and units larger than the individual. It was called the Person-in-Environment Classification System, or PIE (Karls &

Wandrei, 1996a, 1996b). It is built around two major premises: recognition of social considerations and the person-in-environment stance—the cornerstone on which all social work practice rests. Knowledge of the PIE is relevant for all mental health social workers regardless of educational level because of its emphasis on situational factors (Karls & O'Keefe, 2008, 2009).

The PIE system calls first for a social work assessment that is translated into a description of coding of the client's problems in social functioning. Social functioning is the client's ability to accomplish the activities necessary for daily living (e.g., obtaining food, shelter, and transportation) and fulfill major social roles as required by the client's subculture or community (Karls & Wandrei, 1996a, p. vi).

Originally designed to support the use of the *DSM-IV* rather than as a substitute for it, the PIE's purpose was to evaluate the social environment and to influence the revisions of the *DSM*. Essentially, the PIE provided social workers and social work educators with a tool that allowed environmental factors to be considered of primary importance. The PIE, an environmentally sensitive tool, supplemented the descriptive system of the *DSM* that related the mental illness to the human condition, utilizing a holistic, ecological, and pluralistic approach rather than just the diagnosis-focused (medical) foundational basis of the *DSM* (Satterly, 2007).

Social workers proposed an ecosystems perspective incorporating the assumption that clinical practice needs to include the individual within his or her social environment and that his or her actions cannot be separated from his or her support system. Therefore, the PIE adopted features of the *DSM-IV* and *DSM-IV-TR* multiaxial diagnostic system in its assessment typology and had a notable influence on *DSM* revisions, particularly in the area of recognizing environmental problems. One concrete example of the PIE's influence on the *DSM-IV* is the change of Axis IV of the diagnostic system to reflect "psychosocial and environmental problems" where the problem is clearly listed; in the past the *DSM-III-R* Axis IV merely listed the "severity of psychosocial stressors" and ranked the problem on a scale. Although the multiaxial system has been deleted in *DSM-5*, Chapter 22 lists "Other Conditions That May Be a Focus of Clinical Attention," which continue to be used.

The PIE was formulated in response to the need to identify client problems in a way that health professionals could easily understand (Karls & Wandrei, 1996a, 1996b). As a form of classification system for adults, the PIE provides:

- A common language with which social workers in all settings can describe their clients' problems in social functioning.
- A common capsule description of social phenomena that can facilitate treatment or ameliorate problems presented by clients.
- A basis for gathering data to be used to measure the need for services and to design human service programs to evaluate effectiveness.
- A mechanism for clearer communication among social work practitioners and between practitioners, administrators, and researchers.
- A basis for clarifying the domain of social work in human service fields (Karls & Wandrei, 1996a).

In professional practice, tools such as the PIE can facilitate the identification and assessment of clients from a person-in-environment perspective that is easy for social workers to accept as comprehensive. When compared with the *DSM-IV-TR* and *DSM-5,* the PIE provides mental health professionals with a classification system that enables them to codify the numerous environmental factors considered when they

look at an individual's situation. Classification systems like the PIE allow mental health professionals to first recognize and later systematically address social factors in the context of the client's environment. The PIE can help professionals to obtain a clearer sense of the relationship the problem has to the environment in a friendly and adaptable way.

PROFESSIONAL TRAINING IN THE PROFESSIONAL COUNSELING FIELDS

This book is written as a guide for several different disciplines of health and mental health professionals. Similar to the *DSM,* this book is designed to support use in medicine and psychiatry, psychology, social work, nursing, and counseling. This type of integration, with so many diverse yet similar fields, is no easy task because different professions follow different practice models and methods. Yet regardless of which discipline a professional is trained in, there is often great overlap of therapeutic knowledge and skill. In the next chapter, special attention is given to how to apply the diagnostic framework outlined in *DSM-5.*

If practitioners are going to continue to utilize diagnostic assessment systems in the future, there are major implications for professional training and education. MacCluskie and Ingersoll (2001) are quick to remind us that, if professionals of different disciplines are going to use the *DSM,* training and adequate preparation in its use in classroom instruction and as part of a practicum or internship is required. This requires adopting a more homogeneous approach to education and application among all helping disciplines. Other professionals, such as Horn (2008), remind us that all current interpretations must remain flexible and that, as we adopt the new version, *DSM-5,* we must remain vigilant of the ethical concerns that can result from misuse of this important diagnostic tool.

In today's practice environment, most would argue that the interdisciplinary approach of professionals working together to help the client is here to stay. To provide this homogeneity from a practice perspective, almost all professional helpers share one goal: to "help clients manage their problems in living more effectively and develop unused or underused opportunities more fully" (Egan, 1998, p. 7). Now, to extend unification while ensuring competent, ethical, and homogeneous practice, these helping disciplines will also need to unite in terms of professional education, mission, and goals. The first principle for the unification of professional education across disciplines is that (regardless of whether it is for social work, psychology, or other fields of professional counseling) training programs need to be more uniform and specific about what professional training entails and the effect it has on those who participate. When training can be defined in a reasonably specific manner and measured empirically, these professions will better assess its effects on client behavior. With the contemporary emphasis on professional accountability, the effort to predict and document specific outcomes of professional training is timely as well as warranted. The data also suggest that one way professional training can be further enhanced is through differential selection of specified treatment methods. Training in these different treatment methods allows different causative variables (i.e., feelings and actions) to be identified in the course of assessing the client's behavior. Some researchers believe that sticking primarily to traditional methods, which are still a great part of professional training that emphasizes dispositional diagnoses (i.e., the direct relationship of the diagnosis and how it will relate to discharge), may result in diminishing accuracy of behavior assessment (Dziegielewski, 2013).

Educators can improve the accuracy of client behavioral evaluations through the introduction of

specific training in behavioral assessment. This may be the primary reason that in health care, the behaviorally based biopsychosocial approach has gained popularity. Clinical assessment, particularly when it emphasizes client behaviors, is a skill that can easily be taught, transmitted, and measured. Therefore, professional training that includes behavioral observation on how to construct observable and reliable categories of behavior and various systems of observation is recommended.

SUMMARY

As emphasized in this chapter, the *International Classification of Diseases* and the *Diagnostic and Statistical Manual of Mental Disorders* reflect the official nomenclature used in mental health and other health-related facilities in the United States. Diagnostic assessment systems such as the *DSM,* the *ICD*, and the PIE are three descriptive (categorical) classification schemes that cross all theoretical orientations.

The concept of understanding mental disorders; their taxonomical categorization; the formulation and completion of a diagnosis, assessment, or the diagnostic assessment; and their definitions and meanings are embedded in the history of the *DSM*. Exactly what constitutes *diagnosis* and what constitutes *assessment* remains blurred and overlapping, with the words used interchangeably yet remaining distinct and interrelated. For all professional practitioners, compelling demands and pressures related to practice reimbursement clearly emphasize the need for coordination in providing mental health care and subsequent intervention. Despite the differences among the disciplines, all mental health professionals need to be familiar with and able to apply the criteria used in the *DSM* diagnosis.

Because of the increasing demands related to evidence-based practice to achieve outcomes to assess quality, the effectiveness of service delivery, and the collection of data, numerous diagnosis and assessment measurements are currently available. Many are structured in unique categories and classification schemes. Whether this categorical approach used in the *DSM* is replaced by a dimensional one in the *DSM-5* still remains to be seen (Helzer et al., 2008). Utilizing the current system, this text demonstrates the application of these classification schemes and describes how assessment, treatment planning, and intervention become intertwined (Dziegielewski, 2008). Because assessment and treatment are based primarily on the practitioner's clinical judgment and interpretation, a thorough grounding in these classification systems will help the practitioner make relevant, useful, and ethically sound evaluations of clients.

Practitioners need to remain familiar and update their knowledge with some of the major formal methods of diagnosis and assessment, especially the ones most commonly used for billing of mental health services. The changes made over time and efforts toward betterment within the criteria outlined in the *DSM* have moved it toward becoming the best diagnostic tool possible. All mental health practitioners, regardless of discipline, can benefit by utilizing this information to systematically interpret and assist clients in understanding what the results of the diagnostic assessment mean and how best to select empirically sound and ethically wise modes of practice intervention.

No matter whether we call what professional practitioners do assessment, diagnosis, or a combination resulting in the diagnostic assessment, the function remains a critical part of the helping process. Diagnosis and assessment is the critical first step to formulating the plan for intervention (Dziegielewski et al., 2002; Dziegielewski & Leon, 2001). The plan for intervention sets the entire tone and circumstances of the professional helping process. As Dziegielewski (2013) has stated, based on the

general context of reimbursement or fee for service, is it wise for all professionals to continue to struggle to differentiate diagnosis and assessment? Unfortunately, with the shift in mental health care to market-based services, practice and methods have evolved to reflect specialization, integration, and cost-effectiveness as part and parcel of service delivery. Now the question that arises is: Who is eligible to make a diagnosis or an assessment? Professionals are lobbying, and professional licensures reflect this transition and can help to provide public accountability.

Today, the role of the practitioner is twofold: (1) ensure that high-quality service is provided to the client and (2) provide the client access and opportunity to see that his or her health and mental health needs are addressed. Neither of these tasks is easy or popular. Amid this turbulence, the role and necessity of the services that the practitioner provides in assessment and intervention remain clear. All helping professionals must know and utilize the tools of diagnostic assessment and demonstrate competence in properly completing diagnostic assessment—the first step in the treatment hierarchy. To achieve this, it is crucial that health and mental health professionals have comprehensive training in this area to meet current requirements and service needs in an environment filled with limitations and shortages. The question remains: How can we best help the clients we serve?

QUESTIONS FOR FURTHER THOUGHT

1. Is there a difference between the terms *diagnosis* and *assessment?* How would you define the diagnostic assessment, and what client-relevant factors are the most important to identify?
2. Are these terms treated differently and assumed to have different meanings if the practitioner is in a particular health or mental health setting?
3. What do you believe is the most helpful aspect of using manuals such as the *DSM-5* in the diagnostic process?
4. What do you feel are the least helpful aspects of using manuals such as the *DSM-5* in professional practice?
5. Do you believe that use of the *DSM* as a diagnostic/assessment tool will facilitate your practice experience? Why or why not?

REFERENCES

Ahn, W., & Kim, N. S. (2008). Causal theories of mental disorder concepts. *Psychological Science Agenda*, *22*(6), 3–8.

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. Washington, DC: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.

American Psychiatric Association. (1995). *Diagnostic and statistical manual of mental disorders* (4th ed., rev). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Bernstein, C. A. (2011). Meta-structure in the *DSM-5* process. *Psychiatric News*, *46*(5), 7–29.

Boggs, C. D., Morey, L. C., Skodol, A. E., Shea, M. T., Sanislow, C. A., Grilo, C. M., . . . Gunderson, J. G. (2005). Differential impairment as an indicator of sex bias in *DSM-IV* criteria for four personality disorders. *Psychological Assessment*, *17*, 492–496.

Braun, S. A., & Cox, J. A. (2005). Managed mental health care: Intentional misdiagnosis of mental disorders. *Journal of Counseling and Development*, *83*, 425–433.

Brendel, D. H. (2001). Multifactorial causation of mental disorders: A proposal to improve the *DSM*. *Harvard Review of Psychiatry*, *9*(1), 42–45.

Bureau of Labor Statistics, U.S. Department of Labor. (2012). *Occupational outlook handbook, social workers, 2012–2013 ed*. Retrieved from: http://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-3

Caplan, P. J. (2012, April 27). Psychiatry's bible, the *DSM*, is doing more harm than good. *The Washington Post*. Retrieved from http://www.washingtonpost.com

Carlton, T. O. (1984). *Clinical social work in health care settings: A guide to professional practice with exemplars*. New York, NY: Springer.

Carlton, T. O. (1989). Classification and diagnosis in social work in health care. *Health and Social Work*, *14*(2), 83–85.

Colby, I., & Dziegielewski, S. F. (2010). *Introduction to social work: The people's profession* (3rd ed.). Chicago, IL: Lyceum Books.

Davis, S. R., & Meier, S. T. (2001). *The elements of managed care: A guide for helping professionals*. Belmont, CA: Brooks/Cole.

Dumont, M. P. (1987). A diagnostic parable: First edition, unrevised. *Journal of Reviews and Commentary in Mental Health*, *2*, 9–12.

Dziegielewski, S. F. (2008). Brief and intermittent approaches to practice: The state of practice. *Journal of Brief Treatment and Crisis Intervention*, *8*(2), 147–163.

Dziegielewski, S. F. (2013). *The changing face of health care social work: Opportunities and challenges for professional practice* (3rd ed.). New York, NY: Springer.

Dziegielewski, S. F., Johnson, A., & Webb, E. (2002). *DSM-IV* and social work professionals: A continuing education evaluation. *Social Work in Mental Health*, *1*(1), 27–41.

Dziegielewski, S. F., & Leon, A. M. (2001). Time-limited case recording: Effective documentation in a changing environment. *Journal of Brief Therapy*, *1*(1).

Egan, G. (1998). *The skilled helper: A problem management approach to helping* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Eysenck, H. J., Wakefield, J. A. Jr., & Friedman, A. F. (1983). Diagnosis and clinical assessment: The *DSM-III*. *Annual Review of Psychology*, *34*, 167–193.

Feisthamel, K. P., & Schwartz, R. C. (2009). Differences in mental health counselors' diagnoses based on client race: An investigation of adjustment, childhood, and substance-related disorders. *Journal of Mental Health Counseling*. Retrieved from http://www.thefreelibrary.com/Differences+in+mental+health+counselors%27+diagnoses+based+on+client . . . -a0193182088

First, M. B., & Westen, D. (2007). Classification for clinical practice: How to make *ICD* and *DSM* better able to serve clinicians. *International Review of Psychiatry*, *19*(5), 473–481.

Helzer, J. E., Kraemer, H. C., Krueger, R. F., Wittchen, H. U., Sirovatka, P. J., & Regier, D. A. (Eds.). (2008). *Dimensional approaches in diagnostic classification: Refining the research agenda for* DSM-V. Washington, DC: American Psychiatric Association.

Hinshaw, S. P., & Stier, A. (2008). Stigma in relation to mental disorders. *Annual Review of Clinical Psychology*, *4*, 269–293.

Hoffer, A. (2008). Child psychiatry: Does modern psychiatry treat or abuse? *Journal of Orthomolecular Medicine*, *23*(3), 139–152.

Horn, P. (2008). Psychiatric ethics consultation in light of the *DSM-V*. *HEC Forum*, *20*(4), 315–324.

Kaplan, M. (1983a). A woman's view of *DSM-III*. *American Psychologist*, *38*, 786–792.

Kaplan, M. (1983b). The issue of sex bias in *DSM-III*: Comments on articles by Spitzer, Williams, and Kass. *American Psychologist*, *38*, 802–803.

Karls, J. M., & O'Keefe, M. E. (2008). *The PIE Manual*. Washington, DC: NASW Press.

Karls, J. M., & O'Keefe, M. E. (2009). Person in environment system. In A. R. Roberts (Ed.), *Social workers' desk reference* (2nd ed., pp. 371–376). New York, NY: Oxford University Press.

Karls, J. M., & Wandrei, K. M. (Eds.). (1996a). *Person-in-environment system: The PIE classification system for social functioning problems*. Washington, DC: NASW Press.

Karls, J. M., & Wandrei, K. M. (1996b). *PIE manual: Person-in-environment system: The PIE classification system for social functioning problems*. Washington, DC: NASW Press.

Kass, F., Spitzer, R. L., & Williams, J. B. W. (1983). An empirical study of the issue of sex bias in the diagnostic criteria of *DSM-III* Axis II personality disorders. *American Psychologist*, *38*, 799–801.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of twelve-month *DSM-IV* disorders in the national comorbidity survey replication (NCS-R). *Archives of General Psychiatry*, *62*, 617–627.

Kielbasa, A. M., Pomerantz, A. M., Krohn, E. J., & Sullivan, B. F. (2004). How does clients' method of payment influence psychologists' diagnostic decisions? *Ethics and Behavior*, *14*, 187–195.

Kraemer, H. C., Shrout, P. E., & Rubio-Stipec, M. (2007). Developing the diagnostic and statistical manual V: What will "statistical" mean in the *DSMV*? *Social Psychiatry and Psychiatric Epidemiology*, *42*, 259–267.

Kutchins, H., & Kirk, S. A. (1986). The reliability of *DSM-III*: A critical review. *Social Work Research and Abstracts*, *22*, 3–12.

Kutchins, H., & Kirk, S. A. (1988). The business of diagnosis. *Social Work*, *33*, 215–220.

Kutchins, H., & Kirk, S. A. (1993). DSM-IV and the hunt for gold: A review of the treasure map. *Research on Social Work Practice*, *3*(2), 219–235.

Kutchins, H., & Kirk, S. A. (1997). *Making us crazy. DSM: The psychiatric bible and the creation of mental disorders*. New York, NY: Free Press.

MacCluskie, K. C., & Ingersoll, R. E. (2001). *Becoming a 21st century agency counselor*. Belmont, CA: Brooks/Cole, Thompson Learning.

Mayes, R., & Horwitz, A. V. (2005). *DSM III* and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences*, *41*(3), 249–267.

Moses, T. (2009). Stigma and self-concept among adolescents receiving mental health treatment. *American Journal of Orthopsychiatry*, *79*(2), 264–274.

Muller, R. J. (2008). *Doing psychiatry wrong: A critical and prescriptive look at a faltering profession*. New York, NY: Analytic Press.

Pomerantz, A. D., & Segrist, D. J. (2006). The influence of payment method on psychologists' diagnostic decisions regarding minimally impaired clients. *Ethics and Behavior*, *16*(3), 253–263.

Sadler, J. Z. (Ed.). (2002). *Descriptions & prescriptions: Values, mental disorders and the DSMs*. Baltimore, MD: Johns Hopkins University Press.

Sadler, J. Z., Fulford, B., & Phil, M. B. (2004). Should patients and their families contribute to the *DSM-V* process. *Psychiatric Services*, *55*, 133–138.

Satterly, B. A. (2007). The alternative lenses of assessment: Educating social workers about psychopathology. *Teaching in Social Work*, *27*(3/4), 241–257.

Shannon, S., & Heckman, E. (2007). *Please don't label my child: Break the doctor–diagnosis–drug cycle and discover safe, effective choices for your child's emotional health*. New York, NY: Rodale.

Sommers-Flanagan, R. S., & Sommers-Flanagan, J. (2007). *Philosophical foundations*. Hoboken, NJ: Wiley.

Spitzer, R. L., Williams, J. B. W., & Skodol, A. E. (1980). *DSM-III*: The major achievements and an overview. *American Journal of Psychiatry*, *137*, 151–164.

Tsou, J. Y. (2007). Hacking on the looping effects of psychiatric classifications: What is an interactive and indifferent kind? *International Studies in the Philosophy of Science*, *21*(3), 329–344.

Whiting, L. (1996). Foreword. In J. M. Karls & K. M. Wandrei (Eds.), *Person-in-environment system: The PIE classification system for social functioning problems* (pp. xiii–xv). Washington, DC: NASW Press.

Williams, J. B. W., & Spitzer, R. L. (1983). The issue of sex bias in *DSM-III*: A critique of "A woman's view of *DSM-III*" by Marcie Kaplan. *American Psychologist*, *38*, 793–798.

Zachar, P., & Kendler, K. S. (2007). Psychiatric disorders: A conceptual taxonomy. *American Journal of Psychiatry*, *164*, 557–565.

Zimmerman, M. (1988). Why are we rushing to publish *DSM-IV? Archives of General Psychiatry*, *45*, 1135–1138.