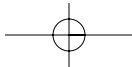
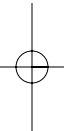
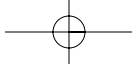


SECTION I

**UTILIZING THE
*DSM-IV-TR***

**Assessment, Planning,
and Practice Strategy**



CHAPTER**I****Getting Started**

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 behaviorally based biopsychosocial field of practice. To start this endeavor, we introduce the major diagnostic–assessment schemes utilized in the profession, along with support and resistance issues. 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. In practice, this rich tradition has been emphasized clearly by compelling demands to address practice reimbursement (S. R. Davis & Meier, 2001). To facilitate this process, 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 the area of health service delivery. Although it is beyond our scope to describe the details and applications of all of these different tools, being familiar with the ones most commonly utilized is essential. Furthermore, this book takes the practicing professional beyond assessment by presenting the most current and up-to-date methods used to support the diagnostic assessment, introducing interventions based on current practice wisdom, while focusing on the latest and most up-to-date evidence-based interventions being utilized in the field.

MENTAL HEALTH ASSESSMENT TOOLS

In practice today, few professionals would debate that the most commonly used and accepted sources of diagnostic criteria are the *Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition Text Revision (DSM-IV-TR)* and the *International Classification of Diseases-Tenth Edition (ICD-10)*. These books are generally considered reflective of the official nomenclature in all mental health and other health-related facilities in the United States. The *DSM-IV-TR* (2000) is the most current version of the APA's *Diagnostic and Statistical Manual*, the revision to this edition (*DSM-V*) is expected to be completed in 2005.

Today, the *DSM* is similar to the *ICD* in terms of diagnostic codes and the billing categories that result; however, this wasn't always the case. As late as the 1980s, clinical practices often used the *ICD* for billing but referred to the *DSM* to clarify diagnostic criteria. It was not uncommon to hear psychiatrists, psychologists, social workers, and mental health technicians complain about the lack of clarity and uniformity in both of these texts. Later versions of these texts responded to the professional outcry of dissatisfaction over the disparity between the two texts by using similar criteria when outlining descriptive classification systems that cross all theoretical orientations. Historically, while most clinicians are knowledgeable about both books, the *DSM* appears to have gained the greatest popularity in the United States and is the resource most often used by psychiatrists, psychologists, psychiatric nurses, social workers, and other mental health professionals. For example, a past survey reported that for clinical social workers working in the area of mental health the *DSM* is the publication used most often (Kutchins & Kirk, 1988). Furthermore, in terms of licensing and certification of most mental health professionals, a thorough knowledge of the *DSM* is considered essential for competent clinical practice.

Since 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 (Corey, 2001a). Nevertheless, 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 are 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 the battle was being fought on the wrong battlefield and advocated for a more comprehensive system of reimbursement that took into account environmental aspects. Furthermore, research findings have suggested that when engaging in clinical practice many professionals did not use *DSM* to direct their

interventions at all. Rather, the focus and use of the manual was primarily limited to ensuring third-party reimbursement, qualifying for agency service, or to avoid placing a diagnostic label. For these reasons, clients were being given diagnoses not based solely on diagnostic criteria, and the diagnostic labels assigned were being connected to unrelated factors such as reimbursement. Therefore, some mental health professionals were more likely to pick the most severe diagnosis so that their clients could qualify for agency services or insurance reimbursement. However, other mental health professionals engaged in the opposite behavior by assigning clients the least severe diagnosis to avoid stigmatizing and labeling them (Kutchins & Kirk, 1986). Although use of the *DSM* is clearly evident in mental health practice, there are those professionals who question whether it is being utilized properly.

Regardless of the controversy in mental health practice, the continued and increased popularity of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* makes it the most frequently used publication in the field of mental health.

The publisher of the *DSM* is the American Psychiatric Press, a professional organization in the field of psychiatry. Nevertheless, the majority of copies are bought and used by individuals who are not psychiatrists. Furthermore, 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 (American Psychiatric Association [APA], 2000). Since most mental health professionals believe there is a need for a system that accurately identifies and classifies biopsychosocial symptoms as a basis for assessing mental health problems, it is no surprise that this book continues to gain popularity.

For some professionals such as social workers, however, the controversy over using this system for diagnostic assessments remains. Regardless of the school of thought or specific field of training a mental health practitioner ascribes to, most professionals would agree that there is no single diagnostic system that is completely acceptable by all. Furthermore, some degree of relative skepticism and questioning of the appropriateness of the use of this manual is useful. Placing a diagnostic label needs to reach beyond ensuring service reimbursement and can have serious consequences for the individual client. Knowledge of how to properly use the manual is needed. In addition, there must also be knowledge, concern, and continued professional debate about the appropriateness and the utility of certain diagnostic categories to discourage abuse.

HISTORY AND RESERVATIONS ABOUT THE DSM

The APA published the first edition of the *DSM* in 1952. This edition was an attempt to blend the psychological with the biological and to provide for the

practitioner a unified approach known as the psychobiological point of view. With 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. Rather, 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 in the clients who were served (Eysenck, Wakefield, & Friedman, 1983). There was so much diagnostic play within the categories that the diverse professionals and differing backgrounds of those who utilized the manual could result in destructive negative labels being placed on the clients served.

This fear of potentially harming clients by attaching diagnostic labels to them made many professionals cautious. They warned of the dangers of using guides such as the *DSM* by arguing that the differences inherent in the basic philosophy of mental health practitioners could lead to interpretation problems. For example, Carlton (1984) and Dziegielewski (1998) felt that social workers, one of the 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 based on pathology and linked to the traditional medical model, a

QUICK REFERENCE

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) tried to calm the controversy by claiming to be unbiased and more scientific. Even though many of the earlier problems still persisted, these problems were overshadowed by an increasing demand for *DSM-III* diagnoses being required for clients to qualify for reimbursement from private insurance companies or from governmental programs.
- *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 ethics of its use.
- *DSM-IV* (1994) sought to dispel earlier criticisms of the *DSM*. The book included additional cultural information, diagnostic tests, and lab findings and was based on 500 clinical field trials.
- *DSM-IV-TR* (2000) does not change the diagnostic codes or criteria from the *DSM-IV*; however, it supplements the current categories with additional information based on the research studies and field trials completed in each area.

perspective very different from the focus of social work. In social work, a strengths-based perspective (i.e., clients are helped to manage their lives effectively under conditions of physical or mental illness and disability) is stressed.

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).

Furthermore, other professionals in the 1980s argued over the alleged masculine bias of the system and the lack of supportive research (M. Kaplan, 1983a, 1983b; Kass, Spitzer, & Williams, 1983; 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. Many professionals believed that the earlier problems still persisted; however, these problems were overshadowed by an increasing demand for use of the *DSM-III* for clients to qualify for reimbursement from private insurance companies or from governmental programs. The major complaint against this edition of the *DSM* was that the information was not well grounded in evidence-based practice.

The APA was challenged to address this issue by an immediate call for independent researchers to be allowed to critically evaluate the diagnostic categories and test its reliability. Soon after this call for increased evaluation, the developers initiated a call of their own seeking research that would support a new and improved revision of this edition of the manual to be called 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 these attempts for independent research by aborting the process, making these attempts obsolete because of the proposed revision. Therefore, all the complaints about the lack of reliability in regard to the *DSM-III* now became moot because all attention now focused on the revision.

The resulting revision, the *DSM-III-R* (1987) did not end the controversy. Despite data from field trials that the developers claimed validated the system on scientific grounds, serious questions were raised about its diagnostic reliability, possible misuse, potential for misdiagnosis, and ethics of its use (M. P. Dumont, 1987; Kutchins & Kirk, 1986). Researchers such as Kutchins and Kirk (1993) noted that although the new edition preserved the same structure and all of the innovations of the *DSM-III*, there were many changes in specific diagnoses. These changes resulted in over 100 categories being altered, dropped, or added. The complaint was that no one would ever know whether the changes improved or detracted from diagnostic reliability when comparing the new manual with the old. Furthermore, attempts to follow-up on the original complaints about the actual

overall reliability of the *DSM-III* were not addressed, nor were any attempts made to test the overall reliability of the *DSM-III-R*, even after it was published.

Once again, the APA heard these comments and less than one year after the publication of the *DSM-III-R* the APA initiated the next revision. *DSM-IV* was originally scheduled for publication in 1990 and was grounded in research. 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 over 150 literature reviews as well as reports outlining the data analysis and re-analysis and reports from the field trials. In addition, the four volumes of the sourcebook culminated the final decisions made by the task and work groups, presenting the rationale in an executive summary (APA, 1995). However, because of this emphasis on evidence-based diagnostic categories and the resulting criteria, publication was delayed until May 1994. Questions continued to be raised about the new edition after it was published. Some professionals questioned whether the *DSM-IV* would detract attention and efforts toward substantiating earlier versions of the manual. It was felt that simply adopting this newer version of the *DSM* without clearly addressing problems of the earlier version (*DSM-III-R*) could have the same disruptive impact on research in regard to the overall reliability (Zimmerman, 1988).

***DSM-IV-TR*: THE LATEST REVISION**

The latest revision of the *DSM*, the *Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) Text Revision (DSM-IV-TR)*, upon which this text is based, was published in 2000. Although Chapter 2 will discuss this version of the text in detail, a brief summary of the *DSM-IV-TR* is provided here. In 1997, the work and assignments for the new task groups for the text revision were assigned. Since the *DSM* has historically been used as an education tool, it was felt that recent research might be overlooked if a revision wasn't published prior to *DSM-V*, which is anticipated to publish in 2005. Surprisingly, however, even with the addition of much new research and information the *DSM-IV* continued to be relatively up to date.

Basically, in formulating the text revisions none of the categories, diagnostic codes, or criteria from the *DSM-IV* was changed. However, more supplemental information is now provided for many of the current categories. In addition, more information is provided on many of the field trials that were introduced in the *DSM-IV* but were not yet completed or required updated research findings to be applied. Furthermore, special attention was paid to updating the sections in terms

QUICK REFERENCE**INTENT OF THE *DSM-IV-TR* REVISIONS**

According to the American Psychiatric Association, the intent of the latest revision is:

- To correct any factual errors that were identified in the printing of the *DSM-IV*.
- To review information to ensure that information is up to date, including the latest research and supporting information available.
- To make educational improvements to enhance the value of the *DSM* as a teaching tool.
- To be sure the new *ICD-9-CM* codes were included in the text, as many of these codes did not become available until 1996—the year after publication of the *DSM-IV*.

of diagnostic findings, cultural information, and other information to clarify the diagnostic categories (APA, 2000).

DIAGNOSTIC LABELS

Regardless of the controversy surrounding the use of the current and earlier versions of the *DSM* as a diagnostic assessment tool, the use of this and other similar measures continues. One of the biggest concerns remains: that categorizing an individual with a mental health diagnosis can result in a psychiatric label that is difficult to remove. In fact, some mental health professionals feel so strongly against the idea of labeling clients that some continue to resist the use of this assessment scheme in their practice. For example (as will be 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 life-long mental health condition known as *Antisocial Personality Disorder*. Such a label, whether accurately or inaccurately placed, can be very damaging to the client because of the negative connotations that characterize it. Furthermore, the negative connotations that sometimes accompany the diagnostic label of *Conduct Disorder* (i.e., generally nonresponsive to intervention, lack of moral standards, and lack of guilt) may result in the conduct-disordered behaviors (i.e., severe aggression toward people or animals). These types of behaviors are unacceptable by all societal standards yet if part of a diagnosis and the client has no control, the behaviors may be viewed as acceptable or unchangeable in the individual. Therefore, these behaviors are accepted or tolerated because they are related to a mental disorder.

QUICK REFERENCE***DSM-IV-TR*: POSITIVE ASPECTS (PRO) AND
NEGATIVE ASPECTS (CON)****PRO:** Leads to uniform and improved diagnosis.**CON:** Can lead to diagnostic labels.**PRO:** Improves *informed* professional communication through uniformity.**CON:** Provides limited information on the relationship between environmental considerations and aspects of the mental health condition.**PRO:** Provides the basis for a comprehensive educational tool.**CON:** Does not describe intervention strategy.

In utilizing mental health assessment schemes, the placement of a label remains. This is an issue that all clinical practitioners struggle with as they try to balance the needs of the most appropriate assessment criteria with what is most reimbursable for service. In the ideal situation labels would not exist, nor would the 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. All health care professionals feel pressure to focus on diagnostic categories that are most likely to be reimbursed. For mental health practitioners, this requires careful evaluation of what is actually happening with the client and, regardless of reimbursement, what will cause the least difficulty for the client in terms of overcoming a diagnostic label with negative connotations or a label for which treatment is typically not reimbursed.

ANOTHER MENTAL HEALTH ASSESSMENT MEASURE

So great was the discontent with the possibility of placing an unfair label that some professionals decided to create their own diagnostic approach. One such group was social workers who believed strongly in and base all practice strategy on the recognition of the person in environment or person in situation (Colby & Dziegielewski, 2001). 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 and in turn the individual can influence environmental factors.

Impetus toward the development of such a perspective was based on criticisms such as Carlton's (1984), which pointed out that since mental health practitioners had not developed their own classification and diagnostic system they were forced to

use psychiatric-based typologies. This reliance was problematic because psychiatric typologies developed for classification of mental illness were not adequate for taking into account the environmental influences. Since these existing categories did not involve psychosocial situations or units larger than the individual, problems were not viewed from an environmental context thereby reducing the problems to being classified as a mental illness (Carlton, 1984). This absence of an accepted system of classification and diagnosis for social work created a burden for practitioners. Since insurance companies required a medical diagnosis before service reimbursement, social workers, as well as psychologists and other mental health professionals, waged a long and difficult fight to use *DSM* independently for third-party payment purposes.

Support for a new diagnostic classification scheme emerged (Karls & Wandrei, 1996a). This new system was designed to focus on these aspects (psychosocial situations, units larger than the individual) and was called the Person-in-Environment Classification System or PIE (Karls & Wandrei, 1996a, 1996b). The PIE was 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). Basically, the PIE is built around two major premises: recognition of social considerations and the person-in-environment stance—the cornerstones on which all social work practice rests.

When the PIE was created, it was originally designed to support the use of the *DSM-IV*, not substitute for it. Its purpose was to evaluate the social environment and to impact the revisions of the *DSM*. Therefore, the PIE adopted features of the *DSM* multiaxis system in its assessment typology and had a notable influence on the revisions of the *DSM*, particularly in the area of recognizing environmental problems. One concrete example of the PIE's influence on the *DSM-IV* is when Axis IV of the diagnostic system was changed to reflect “psychosocial and environmental problems,” from the previous focus of the *DSM-III-R* Axis IV, which listed the “severity of psychosocial stressors.”

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

1. Common language for social workers in all settings to describe their clients' problems in social functioning.

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 (for example, obtaining food, shelter, and transportation) and to fulfill major social roles as required by the client's subculture or community. (Karls & Wandrei, 1996a, p. vii)

2. A common capsulated description of social phenomena that could facilitate intervention or ameliorate problems presented by clients.
3. A basis for gathering data needed to measure the need for services and to design human service programs to evaluate effectiveness.
4. A mechanism for clearer communication among social work practitioners, administrators, and researchers.
5. A basis for clarifying the domain of social work in human service fields.

In professional practice, tools such as the PIE can facilitate the identification and assessment of clients in a way that health professionals can easily understand (Karls & Wandrei, 1996a, 1996b).

These practitioners believe that usage of the PIE, when compared to the *DSM-IV* and the *DSM-IV-TR*, allows mental health professionals a way to further codify the numerous environmental factors that must be considered when looking at an individual's situation. Classification systems such as the PIE offer mental health professionals a way to systematically address social factors in the context of the client's environment. Systems such as this can assist professionals in obtaining a clear sense of the relationship the problem has to the environment in a friendly and adaptable way.

DSM-IV IN ACTION: UTILIZATION OF MENTAL HEALTH ASSESSMENT

Mental health professionals have a unique role in assessment and diagnosis that cannot be underestimated.

As part of either an interdisciplinary or multidisciplinary team, the mental health professional brings a wealth of information in regard to the environment and family considerations essential to practice strategy. If the mental health professional takes the perspective that emphasizes client skill building and strength enhancement, he or she will be well equipped to play a key role in the psychosocial assessment of the client as well as to establish the treatment plan that will guide and determine future service delivery (Slomski, 2000).

For practitioners, the hesitancy and reluctance to differentiate between what constitutes a diagnosis or diagnostic impression and what constitutes a thorough assessment can create obvious difficulties in practice focus and strategy. Therefore, one major purpose of this chapter is to explore the relationship between diagnosis and assessment and determine exactly what the differences are, and when it is best to use one term or the other. To facilitate practice strategy, a combination approach utilizing the meaning inherent in each term is suggested.

QUICK REFERENCE**MULTIDISCIPLINARY TEAMS**

The term multidisciplinary can best be explained by dividing it into its two roots, *multi* and *discipline*. Multi means many or multiple professionals. Discipline means the field of study a professional engages in. When combined, professionals from both disciplines work together to address a common problem. Generally, the multidisciplinary team is composed of several different health and social welfare professionals. These professionals can include physicians, nurses, social workers, physical therapists, and so on. Each of these professionals generally works independently to solve the problems of the individual. Afterward, these opinions and separate approaches are brought together to provide a comprehensive method of service delivery for the client. The role of each professional on the team is usually clearly defined and each team member knows the role and duties that they are expected to contribute. Communication between the professionals is stressed and goals are expected to be consistent across the disciplines, with each contributing to the overall welfare of the client. The multidisciplinary team approach seems to be losing its appeal in today's health care environment, and inclusion of a more collaborative and integrative approach is being highlighted (Dziegielewski, 1998).

INTERDISCIPLINARY TEAMS

Similar to the multidisciplinary team, the interdisciplinary team consists of a variety of health care professionals. The major difference between the multidisciplinary approach and the interdisciplinary one is that the latter takes on a much more holistic approach to health care practice. Interdisciplinary professionals work together throughout the process of service provision. Generally, a plan of action is developed by the team. In service provision, the skills and techniques that each professional provides can and often do overlap. A combining of effort similar to the multidisciplinary team is achieved; however, interdependence throughout the referral, assessment, treatment, and planning process is stressed. This is different than the multidisciplinary team where assessments and evaluations are often completed in isolation and later shared with the team. In the interdisciplinary team process, each professional team member is encouraged to contribute, design, and implement the group goals for the health care service to be provided (Dziegielewski, 1998).

DIAGNOSIS AND ASSESSMENT: IS THERE A DIFFERENCE?

The formulation of an assessment that leads to the diagnosis of a client's mental health problems has been a serious source of debate within the profession. According to Carlton (1984), the debate stems from the fact that there are no clear differences when defining what is meant by the terms *diagnosis* and *assessment*.

When looking specifically at the features inherent in the diagnosis, the same features remain and actually overlap in the definition of the assessment. In today's practice environment, it is not uncommon to use these words interchangeably (Dziegielewski, 1996, 1998; Dziegielewski & Holliman, 2001). When documenting treatment for reimbursement, however, it is probably better to use *assessment* or *diagnostic assessment* in place of *diagnosis* (Dziegielewski & Leon, 2001a). The primary reason for this is that assessment is often not directly related to the medical model, whereas historically the term diagnosis often is (Barker, 1995).

In the application of mental health practice, when two elements within the same process are not considered distinct, confusion can result. This allows the concepts inherent in each to blur and overlap in terms of application. This is further complicated by the multiplicity of meanings that can be applied to the terms used to describe each aspect. When applied directly to behaviorally based practice, the major difficulty occurs in differentiating clearly within the professional intervention "what constitutes an assessment" and "what constitutes the diagnosis." Furthermore, this lack of clarity of definition can result in health and mental health professionals applying social, personal, and professional interpretations that are varied and nonuniform.

Diagnosis

It is easy to see how the actual definition, criteria, and subsequent tasks of assessment and diagnosis can be viewed as very similar. This overlap of definition and criteria, however, is not always shared among the other professions. For example, in nursing assessment often has been viewed as precluding the diagnosis. In this interpretation, the assessment is the building

diagnosis: [t]he process of identifying a problem (social and mental, as well as medical) and its underlying causes and formulating a solution. In early social work delineation, it is one of the three processes, along with social study and treatment. Currently, many social workers prefer to call this process assessment because of the medical connotations that often accompany the term "diagnosis." Other social workers think of diagnosis as the process of seeking underlying causes and assessment as having more to do with the analysis of relevant information. (Barker, 1995, p. 100)

block on which the diagnosis is established (Rankin, 1996). Since many health and mental health practitioners subscribe to the medical model, this idea of separate and unique functions between assessment and diagnosis requires further exploration. No matter what it is called, or regardless of whether a health or mental health practitioner truly subscribes to or supports this distinction between assessment and diagnosis, awareness of the blurring that exists in defining the two terms is critical.

The most widely accepted definition of diagnosis is based on the medical model. Based on this model, diagnosis is guided by

three related activities: (1) the determination of the identity of a disease or illness supported by concrete somatic, behavioral, or concrete features; (2) ascertaining the cause or etiology of the illness or disease based on these features; and (3) making any diagnostic impression based on a systematic scientific examination (Carlton, 1984).

In fields such as social work and counseling, however, diagnosis is perceived and generally interpreted in a broader sense. Corey (2001b) states that the purpose of diagnosis in counseling and psychotherapy is to “identify the disruptions in a client’s presenting behavior and lifestyle” (p. 52). Furthermore, Corey believes that diagnosis and assessment cannot be separated and must be conceived as a continual process that focuses broadly on understanding the client. To further bridge the gap between viewing diagnosis in isolation, Perlman (1957) warned social workers not to perceive that determining and formulating a diagnosis “. . . would magically yield a cure to a reluctance to come to any conclusion beyond an impression . . . grasping at ready made labels” (p. 165). Perlman defined diagnosis as the identification of both *process* and *product*. According to Perlman, the diagnostic process was defined as “. . . examining the parts of a problem for the import of their particular nature and organization, for the interrelationship among them, for the relationships between them and the means to their solution” (p. 164).

Carlton (1984) further exemplified the issue of process in the diagnostic procedure:

To be effective and responsive, any clinical social work diagnosis must be a diagnosis “for now” a tentative diagnosis. It is the basis of joint problem solving work for the clinician and client. To serve this purpose, the diagnosis must be shared with the client(s) and, as their work gets underway and proceeds through the various time phases of clinical social work process, the diagnosis must change as the configuration of the elements of the problem change. Thus clinical social work diagnosis is evolutionary in character and responsive to the changing nature of the condition or problem in which it relates. (p. 77)

In addressing the diagnostic process, the *diagnostic product* must be obtained. The diagnostic product is generally identified as what is obtained after the counseling professional utilizes the information gained through the diagnostic assessment. This includes drawing inferences and reaching conclusions based on scientific principles that are logically derived from the information obtained. Corey (2001b) suggested that certain questions be asked:

- What is happening in the client’s life now?
- What does the client want from therapy?

- What is the client learning from therapy?
- To what degree is the client applying what is learned?

Corey believed that questions such as these allow for assessment and diagnosis to be joined in a tentative hypothesis, and that these educated hunches can be formed and shared with the client throughout the treatment process. Therefore, to establish a firm foundation for the diagnostic process, the professional therapist must be skilled in obtaining and interpreting the information acquired. In identifying the diagnostic process, Carlton (1984) stressed the importance of recognizing three factors: the biomedical, psychological, and social. He felt that it was essential for professionals to understand the biopsychosocial approach to health care practice and that balance must be obtained between these factors. The balance between these factors, however, does not have to be equal and the area of emphasis can change. It is always the situation experienced by the client that places the most importance on what area must be addressed first.

For example, a client diagnosed with HIV has many issues that must be addressed. First, the emphasis for diagnosis may be placed in the biomedical area. The client may need immediate information to determine whether the medical test used is positive. Medical tests can determine whether the t-cell count (a type of body protection factor) has been obtained. Information yielded by this test can help to establish a baseline for current and future levels of self-protection from illness and opportunistic infectious diseases. Once these tests have been run, the client will need educational services to provide information on the effects of the disease, what infection means, and what to expect as the illness continues.

Once this is addressed, emphasis on the diagnostic focus may shift to the social aspects related to the client's condition. Since this disease is often sexually transmitted, the partners who are or have been sexually active with the client need to be considered. The focus is how to best tell loved ones what has happened and address issues related to what this illness will mean for future social relationships. Later, the emphasis for treatment may shift to the individual client and dealing with many other personal issues that need be resolved. In diagnosis, regardless of what area is emphasized and with what intensity, understanding and integration of the biopsychosocial approach is considered essential.

Once the process has been established, attention has traditionally been focused on the diagnostic product. In measuring the diagnostic product, Falk (1981, as cited in Carlton, 1984), suggested fourteen areas that need to be addressed in providing diagnostic impressions—life stage, health condition, family and other memberships, racial and ethnic memberships, social class, occupation, financial situation, entitlements, transportation, housing, mental functioning, cognition (personal), cognition (capability), and psychosocial elements. Utilizing a biopsychosocial perspective, the areas are further broken down into three

primary categories: biomedical, psychological, and social factors. Since all mental professionals are responsible for assisting with the provision of concrete services, recognition of these factors is often considered part of the practitioner's role in assessment with the addition of a fourth area that addresses the functional/situational factors that affect the diagnostic process.

In summary, historically it has always been essential that the activity of diagnosis be related to the client's needs. A diagnosis is established to help better understand and prepare to address the probable symptoms relative to the mental disorder. Factors that result from the diagnostic procedure are shared with the client when needed and assist in self-help or continued skill building. From a medical perspective, the diagnostic process has been used to examine the situation and provide the basis to initiate the helping process. Later in the treatment regime, the formal diagnostic process will yield and contribute to formal assessment that is based on the information learned. The diagnostic information gathered is used to facilitate the establishment of the intervention plan.

Overall, the mental health professions have embraced the necessity for diagnosis in practice—although this need is often recognized with caution. Furthermore, while accepting the requirement for completion of a diagnosis, much discontent and dissatisfaction among professionals continue to exist. For some mental health professionals, when the diagnosis is referred to in the most traditional sense, reflective of the medical or “illness” perspective, some fear that it will be inconsistent with professional values and ethics. For these professionals, an illness-focused perspective detracts from an individual's capacity for initiative based on self-will or rational choice. Today, however, this view is changing. Many mental health professionals, struggling for practice survival in a competitive, cost-driven health care system, disagree. They feel that practice reality requires that a traditional method of diagnosis be completed in order to receive reimbursement. It is this capacity for reimbursement that influences and determines who will be offered the opportunity to provide service (Steps Taken to Watchdogs for Managed Care, 1997).

Assessment

Currently, most mental health practitioners are active in obtaining and completing assessment within the general context of gathering diagnostic considerations (Corey, 2001a, 2001b). According to Barker (1995), assessment involves “determining the nature, cause, progression, and prognosis of a problem and the personalities and situations involved” as well as understanding and making changes to minimize or resolve it (p. 27). Assessment requires thinking and formulating from the facts within a client's situation to reach tentative conclusions regarding their meaning (Sheafor, Horejsi, & Horejsi, 1997). Therefore, assessment is viewed as an essential ingredient

to start the therapeutic process and is the hallmark of all professional (as opposed to lay) activity. Furthermore, Corey (2001a, 2001b) reminds us that, ideally, assessment is a collaborative process as it becomes part of the interaction between client and therapist. From this perspective, assessment controls and directs all aspects of practice, including the nature, direction, and scope. Corey (2001b) warns, however, that assessment and diagnosis cannot be separated and must be continually updated as part of the intervention process.

For professional practitioners who often fill many different roles as part of the interdisciplinary team, it remains expected that the process of assessment must reflect diversity and flexibility. For the completion of an accurate assessment, environmental pressures and changes in client problem situations make the need to examine and reexamine the client's situation critical. If, in the mental health setting, the process of assessment is rushed, superficial factors may be highlighted and significant ones deemphasized or overlooked. Professionals bear administrative and economic pressures to make recommendations for consumer protection while preserving health care quality.

In general, the problem of differentiating between diagnosis and assessment is not unique to any one of the counseling disciplines. Since none of the helping professions developed in isolation, the assessment process has been influenced by all, including medicine, psychiatry, nursing, psychology and social work, marriage and family therapy as well as other counseling professionals. Historically, assessment has been referred to as *diagnosis* or the *psychosocial diagnosis* (Rauch, 1993). Although Rauch admits there are similarities in the two terms and warns professional helpers not to accept them as interchangeable. In this perspective, diagnosis focuses on symptoms and assigns categories that best fit the symptoms the client is experiencing. Assessment on the other hand is broader and focuses on the person-in-situation or person-in-environment stance.

In practice today, regardless of the exact meaning of the term *diagnosis*, it is often used interchangeably with the term *assessment* (Corey, 2001a, 2001b; Dziegielewski, 1998). This blurring of terminology is becoming so accustomed that even the *DSM-IV* (1994) and *DSM-IV-TR* (2000) use both words, and at times it appears that these words are interchangeable throughout the book when used to describe the diagnostic impression. Therefore, this terminology as well as the helping activities and the practice strategy that result appear to be forced to adapt to the dominant culture (Dziegielewski, 1998). Since these expectations generally deal with reimbursement for service, whether conscious or not, they influence and guide practice intervention and strategy. Unfortunately, pressure within the environment supports the expectation to reduce services to clients, treat only those who are covered by insurance or can pay privately, or terminate clients because the services are too costly (Ethics Meet Managed Care, 1997). Therefore, the role of assessment and diagnosis, regardless of what we call it, is a

critical one because it can determine what, when, and how services will be provided.

A COMBINATION APPROACH: REALIZATION OF THE NEW ASSESSMENT

Dziegielewski (1998) outlined five factors that guide the initiation of accurate assessment that will ultimately relate to the implementation of practice strategy. When working with individuals and preparing to complete an assessment, the following should always be considered:

1. *Examine carefully how much information the client is willing to share and the accuracy of that information.* The information the client is willing to share and the accuracy of what is shared is essential to ensure the depth and application of what is presented as well as the subsequent motivation and behavioral changes that will be needed in the intervention process. Gathering information from the *DSM* and matching it to what the client is reporting requires an awareness of this phenomena and how it can relate to the symptoms that are being reported. Special attention needs to be given not only to what the client is saying but also the context in which this information is revealed. What is going on in the client's life at this time? What are the systemic factors that could be influencing certain behaviors? What will revealing the information mean to family and friends, or how will it affect the client's support system? Gathering this information is important especially since a client may fear that stating accurate information could have negative consequences. For example, clients may withhold information if they feel revealing the information may have legal ramifications (they will be sent to jail), social consequences (rejection of family or friends), or medical implications (re-hospitalization).

2. *As accurate a definition of the problem as possible needs to be gathered as it will not only guide the diagnostic impression, it will also guide the approach or method of intervention that will be used.* Furthermore, the temptation should always be resisted to let the diagnostic impression or intervention approach guide the problem, rather than allowing the problem to guide the approach (Sheafor et al., 1997). This is critical since so much of the problem identification process in assessment is an intellectual activity. Therefore, the professional practitioner should never lose sight of the ultimate purpose of the assessment process, which is to complete an assessment that will help to establish a concrete service plan that can best address a client's needs.

3. *All professional practitioners need to be aware of how their beliefs can influence or affect the interpretation of the problem or both.* An individual's worldview

or paradigm helps to shape the way the world is viewed. Most professionals agree that it is what an individual believes that creates the foundation for which he or she is and how he or she learns. In ethical and moral professional practice, it is essential that these individual influences do not directly affect the assessment process. Therefore, the practitioner's values, beliefs, and practices that can influence treatment outcomes must be clearly identified from the onset of treatment. It is important for the professional practitioner to ask, "What is my immediate reaction to the client and the problem expressed?" Clients have a right to make their own decisions, and the helping professional must do everything possible to ensure this right and not allow personal opinion to impair the completion of a proper assessment. In addition, since counseling professionals often serve as part of an interdisciplinary team, the beliefs and values of the members of the team must also be considered. This makes the awareness of value conflicts that might arise among the other team members essential. Awareness is critical in order to prepare for how personal feelings and resultant opinions might inhibit practitioners from accurately assessing what a client is doing and how the client perceives issues. As part of a team, each member holds the additional responsibility of helping others on the team be as objective as possible in the assessment process. Helping practitioners should always be available to assist these other professionals, and always advocate for how best to serve the client's needs. Values and beliefs can be influential in identifying factors within individual decision-making strategies, and remain an important factor to consider and identify in the assessment process.

4. *Issues surrounding culture and race should be addressed openly in the assessment phase to ensure that the most open and receptive environment is created.* Simply stated, the professional practitioner needs to be aware of his or her own cultural limitations, open to cultural differences, and recognize the integrity and the uniqueness of the client, while utilizing the client's own learning style, including his or her own resources and supports (Dziegielewski, 1996, 1997a).

For example, when utilizing the *DSM-IV*, cultural factors are stressed prior to establishing a diagnosis. The *DSM-IV-TR* (2000) emphasizes that delusions and hallucinations may be difficult to separate from the general beliefs or practices that may be related to a client's specific cultural custom or lifestyle. For this reason, an entire appendix is included in the *DSM-IV-TR* that describes and defines culturally bound syndromes that might affect the diagnosis and assessment process (APA, 1995, 2000).

5. *The assessment process must focus on client strengths and highlight the client's own resources for addressing problems that affect his or her activities of daily living and for providing continued support.* Identifying strengths and resources and linking them to problem behaviors with individual, family, and social functioning, however, may not be as easy as it sounds. Many people have a tendency to focus on the negatives and rarely praise themselves for the good they do.

This is further complicated by time-limited intervention settings where mental health professionals must quickly identify individual and collectively based strengths. The importance of accurately identifying clients' strengths and support networks is critical as later they will also be implemented into the intervention plan that is suggested as a means of continued growth and maintenance of wellness after the formal treatment period has ended.

COMPLETING THE DIAGNOSTIC-ASSESSMENT PROCESS

To initiate the process, it is assumed that the new type of assessment referred to here as the diagnostic assessment begins with the first client-professional practitioner interaction. The information gathered provides the database that will assist in determining the requirements and direction of the helping process. In assessment, it is expected that the professional will gather information about the present situation, a history of past issues, and anticipate service expectations for the future. This assessment should be multidimensional and always include creative interpretation of perspectives and alternatives for service delivery. Information gathered needs to follow a behavioral biopsychosocial approach to practice.

In this type of assessment, the biomedical factors are highlighted including information about the general physical health or medical condition of the client. Information should be considered from the practitioner's perspective as well as the client's perception. In addition, all information gathered needs to show the relationship between the biological or medical factors as well as the functioning level attained by these factors expressed in the ability to complete certain behaviors that maximize independence. In addition, concrete tasks are identified for the focus of increased future change efforts.

The second area to be considered is psychological factors. In this area, psychological functioning as noted through mental, cognitive health functioning is recorded along with how it affects occupational and social functioning. Another

QUICK REFERENCE

BIOMEDICAL FACTORS IN ASSESSMENT

General medical	The physical disability or illness the client reports and what specific ways it effects the client's social and occupational functioning and activities of daily living.
Perceived overall health status	Be sure to encourage the client to assess his or her own health status and assess what he or she is able to do to facilitate the change effort.

QUICK REFERENCE**PSYCHOLOGICAL FACTORS IN ASSESSMENT**

Mental functioning	Describe the client's mental functioning. Complete a mental status measurement. Learn and utilize the multiaxis assessment system.
Cognitive functioning	Does the client have the ability to think and reason what is happening to him or her? Are they able to participate and make decisions in regard to their own best interest?
Assessment of lethality	Would the client hurt him- or herself or anyone else because of the perception of the problem he or she is experiencing?

important area that must also be addressed is lethality. For example, specific questions about whether the client is at risk for suicide or harming others must be asked and processed. If needed, immediate action may be warranted. It is in this portion of the assessment process that information as outlined in the *DSM-IV-TR* multiaxis system is clearly outlined. Chapters 2 and 3 will describe in depth how this is completed.

Last, when incorporating the behaviorally based biopsychosocial approach to assessment emphasis needs to be placed on identifying social and environmental factors. Most professionals would agree that environmental considerations are very important in measuring and assessing all other aspects of a client's needs. Identifying family, social supports, and cultural expectations are all important in helping the client ascertain what is the best course of action.

Generally, the client is seen as the primary source of data. As stated earlier, be sure to take the time to assess the accuracy of the information and determine whether the client may be either willingly or inadvertently withholding or exaggerating the information presented. Assessment is usually gathered through verbal and written reports. Verbal reports may be gathered from the client, significant others, family, friends, or other helping professionals. Critical information can also be derived from written reports such as medical documents, history and physical, previous clinical assessments, lab tests, and other clinical and diagnostic methods. Furthermore, information about the client can be derived through direct observation of verbal or physical behaviors or interaction patterns between other interdisciplinary team members, family, significant others, or friends. When seeking evidence-based practice, recognizing directly what a client is doing can be a critical factor in the diagnostic assessment process. Viewing and recording these patterns of communication can be extremely helpful in later establishing and developing strengths and resources as well as being utilized in the linking of problem behaviors

QUICK REFERENCE**SOCIAL AND ENVIRONMENTAL FACTORS IN ASSESSMENT**

Social/societal help-seeking	Is the client open to outside help? What support system or helping networks are available to the client from those outside the immediate family or the community?
Occupational participation	How does a client's illness or disability impair or prohibit functioning in the work environment? Is the client in a supportive work environment?
Social support	Does the client have support from neighbors, friends, or community organizations (i.e., System church membership, membership in professional clubs)?
Family support	What support or help can be expected from relatives of the client?
Ethnic or religious affiliation	If the client is a member of a certain cultural or religious group, will this affiliation affect medical intervention and compliance issues?

to concrete indicators that reflect a client's performance. Remember that in addition to verbal reports, written reports that are reflective of practice effectiveness will almost always be expected. Often background sheets, psychological tests, or tests to measure health status or level of daily function may be utilized to establish more concrete measurement of client problem behaviors.

Although the client is perceived as the first and primary source of data, the current emphasis on evidence-based practice strategy, which necessitates gathering information from other sources, cannot be overstated. This means talking with the family and significant others to estimate planning support and assistance. It might also be important to gather information from other secondary sources such as the client's medical record and other health care providers. To facilitate assessment, the practitioner must be able to understand the client's medical situation. Knowledge of what certain medical conditions are and when to refer to other health professionals for continued care is an essential part of the assessment process.

In completing a multidimensional diagnostic assessment there are four primary steps for consideration:

1. *The problem must be recognized as interfering with daily functioning.* Here the practitioner must be active in uncovering problems that affect daily living

QUICK REFERENCE**IMPORTANT CONSIDERATIONS FOR COMPLETING THE
NEW DIAGNOSTIC ASSESSMENT**

1. The problem must be recognized and linked to interference of daily functioning.
2. Special consideration must be given to the environmental context in which the behaviors are occurring.
3. Cultural considerations for both the client and the practitioner should be addressed and when possible discussed openly. Once problem behaviors are noted, criterion for the diagnostic impression is important only as it leads to assisting with identifying the needs of the client for a problem-solving strategy.
4. A complete diagnostic assessment involves more than the diagnostic impression, it involves utilizing the information gathered to best help the client and thereby, guide, enhance, and, in many cases, determine the course of treatment.

and engaging the client in self-help or skill building, changing behaviors, or both. It is important for the client to acknowledge that the problem exists, because once this is done “. . . the boundaries of the problem become clear, and exploration then proceeds in a normal fashion” (Hepworth, Rooney, & Larsen, 1997, p. 205).

2. *The problem must be clearly identified.* The problem of concern is what the client sees as important; after all, the client is the one who is expected to create the behavior change. In practice, it is common to receive referrals from other health care professionals. Special attention should always be given to referrals that clearly recommend a course of treatment or intervention. This type of focused referral may limit both the scope and intervention possibilities available to the client and when accepting these types of referrals the best interest of the client should always be paramount. Often focused referrals that limit the scope of the intervention can also provide the basis for reimbursement as well. Although referral information and suggestion should always be considered in your discussion with the client in identifying the problem, in terms of assessment and the resulting plan, the best interests of the client should always be paramount and the client should participate and help to identify the end result.

3. *Problem strategy must be developed.* Here the professional practitioner must help to clearly focus on the goals and objectives that will be followed in the intervention process. In the initial planning stage, identification of mutually agreed on and measurable goals and objective and concrete indicators that the goals and objectives have been reached will assist both the client and the practitioner to ensure practical, useful, and productive changes have been made.

4. *Once the problem strategy and plan are clearly identified, a diagnostic assessment plan must be implemented.* According to Sheafor, Horejsi, and Horejsi (1997) the plan of action is the “. . . bridge between the assessment and the intervention” (p. 135). Therefore, the outcome of the diagnostic assessment process is the completion of a plan that will guide, enhance, and in many cases determine the course of treatment to be implemented (Dziegielewski, 1998). With the complexity of human beings and the problems that they encounter, a properly prepared multidimensional diagnostic assessment is the essential first step for ensuring quality service delivery.

In summary, regardless of what type of tool is used to assist in the diagnostic assessment process, none of these classification systems suggest treatment approaches; they only provide diagnostic and assessment classifications. The intervention plan is derived after the assessment and depends on the practitioner's interpretation. Furthermore, regardless of what type of diagnostic assessment tool is utilized, all practitioners need to be able to: (1) choose, gather, and report this information systematically; (2) be aware and assist other multidisciplinary or interdisciplinary team members in the diagnostic process; (3) interpret and assist the client to understand what the results of the diagnostic assessment mean; and (4) assist the client to choose evidence-based and ethically wise modes of practice intervention.

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 highlight 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 since different professions follow different practice models and methods. Yet, regardless of which discipline a professional was trained in, he or she often has great overlap of therapeutic knowledge and skill. In the next chapter special attention will be given to how to apply the multiaxial diagnostic framework.

In the future, if professional practitioners are going to continue to utilize diagnostic assessment systems 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* each one must be trained and adequately prepared in its use in both classroom instruction and as part of a practicum or internship. This requires a more homogeneous approach to education and application be adopted among all the helping disciplines.

To provide this homogeneity from a practice perspective the answer is clearer since there is one goal that almost all professional helpers share: to “help clients manage their problems in living more effectively and develop unused or underused opportunities more fully” (Egan, 1998, p. 7). In today’s practice environment, few would argue that the interdisciplinary approach of professionals working together to help the client is here to stay. Now, to extend unification and also ensure competent, ethical practitioners, these helping disciplines will also need to unite in terms of professional education. 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, what effect the training has on those who participate? When training can be defined in a reasonably specific manner and measured empirically, these professions will be better able to assess its effects on client behavior. With the contemporary emphasis of 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 in which professional training can be further enhanced is through differential selection of specified treatment methods. Training in these different treatment methods will allow for 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 still comprise a great part of professional training that emphasizes dispositional (i.e., the direct relationship of the diagnosis and how it will relate to discharge) diagnoses, may result in diminishing accuracy of behavior assessment (Case & Lingerfelt, 1974; Dziegielewski, 1998).

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 in popularity. Clinical assessment, particularly when it emphasizes client behaviors, is a skill that can easily be taught, transmitted, and measured. Therefore, it is recommended that professional training include behavioral observation training on how to construct observable and reliable categories of behavior, and training in various systems of observation. This highlights the need for professional education to question training future practitioners in traditional methods when the likely consequence is that accuracy in behavioral assessment will decrease.

SUMMARY

The concept of formulating and completing a diagnosis, assessment, or the diagnostic assessment is richly embedded in the history and practice of many of the

professional fields of helping. The exact definition of what constitutes diagnosis and what constitutes assessment remains blurred and overlapping. In professional practice the words continue to be used interchangeably, which can be confusing as the functions were originally intended to be separate (Dziegielewski, 1996, 1997a, 2001). For all professional practitioners, compelling demands to address practice reimbursement has clearly emphasized this rich tradition. Furthermore, despite the differences that currently exist between the disciplines, the degree to which a professional has power in the therapeutic marketplace rests on the degree to which a profession is licensed to use the *DSM* for diagnosis (MacCluskie & Ingersoll, 2001).

One of the most valid criticisms about the provision of counseling services is the lack of information about quality outcomes (K. Davis, 1998). To address this concern, numerous types of diagnosis and assessment measurements are currently available. Many of these are structured into unique categories and classification schemes. This makes it essential for the practitioner to be familiar with some of the major formal methods of diagnosis and assessment, especially the ones that are most commonly used and accepted in the area of mental health service delivery (S. R. Davis & Meier, 2001). All mental health practitioners, regardless of discipline, need to utilize this information for systematic ways to interpret and assist the client to understand 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 of these resulting in the diagnostic assessment, the function remains a critical part of the helping process. As Dziegielewski (1998) stated, based on the general context of reimbursement or fee-for-service, is it wise for all professionals to continue to struggle for differentiation between the diagnosis and assessment? Once this issue and the differences between the two terms have been brought successfully to the forefront, the question arises about who is eligible to make a diagnosis or an assessment. If this happens in the current turbulent service environment, all professionals may be forced to lobby for providing and justifying something that they have been doing since the early development of the field. Do the various helping professions really want to embark on this quest?

Diagnosis and assessment constitute the critical first step that is essential to formulating the plan for intervention (Dziegielewski & Leon, 2001b; Dziegielewski, Johnson, & Webb, in press). Thus, it is the plan for intervention that sets the entire tone and circumstance to be included in the professional helping process.

To compete in today's current practice environment, the role of the professional practitioner is twofold: (1) to ensure that quality service is provided to the client and (2) that the client has access and is given an opportunity to see that his or her health and mental health needs are addressed. Neither of these tasks is easy

or popular. The push is for behaviorally based practice to be conducted with limited resources and services. The resultant competition to be the one designated as the provider has changed the role of the practitioner as a service provider. Amid this turbulence, the role and necessity of the services the professional practitioner provides in the area of assessment and intervention remain clear. All helping professionals must know and utilize the tools relative to the diagnostic assessment. Proper completion of the diagnostic assessment is the first step in the treatment hierarchy, and it is crucial that health and mental health professionals have comprehensive training in this area.

QUESTIONS FOR FURTHER THOUGHT

1. Is there a difference between the terms *diagnosis* and *assessment*?
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-IV-TR* in the diagnostic process?
4. What do you feel are the least helpful aspects of using manuals such as the *DSM-IV-TR* in professional practice?
5. As a diagnostic/assessment tool, do you believe that use of the *DSM* will facilitate your practice experience? Why or why not?