A training programme in the DSM system for social workers

by

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A TRAINING PROGRAMME IN THE DSM SYSTEM FOR SOCIAL WORKERS

ABSTRACT

The lack of a scope of practice for social workers in South Africa, and with that their right to do mental health diagnoses or even work with mental health clients, has led to conflict. There is not yet a clear agreement between the role players within South Africa, such as the South African Council for Social Service Professions (SACSSP) and South African Association of Social Workers in Private Practice (SAASWIPP). From the initial investigation, it became clear however that social workers in South Africa are often using the DSM system without training.

One of the main concepts, namely 'clinical social work', is well defined in international literature. However, very little literature could be found within the South African context pertaining to who is qualified to be a clinical social worker or a social worker with the right to diagnose. This has caused some conflict on a practical level among social workers and 'clinical' social workers when operating in the field of mental health since the perception exists that some social workers overstep their boundaries or scope of practice.

The research problem was formulated, based on social workers admitting that they are using the DSM system, regardless of their training or lack of training in the DSM system. Social workers do not receive sufficient training in mental health diagnostic systems in undergraduate training.

The purpose of this study was to develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system, namely the DSM system, when dealing with individuals who present with a specific disorder. The hypothesis that directed this research indicated that social workers, who receive formal training in the utilization of the DSM system, would be equipped with knowledge and insight with regard to the

mental health of their clients. This could enhance the profession, since social workers would be able to participate in the multi-professional team with insight with regard to mental health terminology and pathology.

A combined quantitative/qualitative research approach was followed, more specifically applied intervention research since the aim of the study was to contribute towards addressing a practical issue. The research objectives were to complete a literature study regarding social workers' assessment in the context of the DSM system; to explore social workers' knowledge, attitude, and utilization of the DSM system; to develop a training programme and train social workers in the utilization of the DSM; to implement the developed training programme for social workers in the utilization of the DSM; to pilot test the effectiveness and content of the training programme; and to draw conclusions and make recommendations with regard to the benefit for the social work profession as well as to multi-professional teamwork, should social workers receive training programme in the DSM system.

The researcher collected data while the respondents attended a two-day training programme in the DSM system. Respondents completed a pre-test questionnaire as well as a post-test questionnaire on completion of the training programme. This data analysis was based on a quasi-experimental design, namely the 'one-group pre-test-post-test design'. Conclusions and recommendations were made relating to social work training, social work in mental health and the DSM utilization in social work practice.

The limitations of this study were the lack of literature, the need for training over a longer period, and especially the uncertainties regarding a nationally accepted scope of practice for social workers. The need for in-depth evaluation and advanced development of the programme is identified as both a limitation and a recommendation for future research.

KEY WORDS

- Mental health practitioner
- DSM
- Training
- Training programme
- Mental health
- Social work
- Clinical social work
- Mental health team
- Diagnosis
- Intervention research

TABLE OF CONTENTS

LIST OF SCHEMATICAL DESIGNS

LIST OF TABLES

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER1

INTRODUCTION TO STUDY

1.1 INTRODUCTION

So often, the public and professionals will make statements and diagnoses, both formally and informally, regarding the mental health of another individual. The question may arise of what the basis for, or system of such a diagnosis would be? Are social work professionals guilty of diagnosing by assessing without using valid criteria? Is there any value in utilizing one internal assessment and diagnostic system, or will each clinician use a system most applicable to their practice? These are all questions raised by the researcher in a search for answers.

In the researcher's experience as a social worker, she found that agencies expected her to utilize the Diagnostic Statistical Manual of Mental Disorders (DSM) system (within South Africa and the United Kingdom), regardless of her knowledge or lack thereof with respect to this diagnostic system. The DSM is the standard classification of mental disorders used by mental health professionals in the United States and United Kingdom, and is one of the most popular systems in South Africa (Strong, 2007). Because of the researcher's interest in mental health, she studied the DSM system in order to understand the utilization of this system. The self-study aroused concern since she found that social workers utilize the DSM without formal training in the system.

Mental disorders affect the lives of millions of people, not only in South Africa, but also throughout the world. The exact numbers of people who suffer from mental disorders are unknown because so many afflicted people do not come to the attention of the health departments or reporting agencies (Cockerham, 1996:1; Rivelli, 2010:8). The question arises: How do we assess people with disorders known to us and seeking help? One system of assessment or measurement is the DSM system (Huyssen, 1999:11). The DSM provides a system whereby clinicians identify certain signs and symptoms in an individual

in order to make a psychiatric diagnosis. The main function of a psychiatric diagnosis is to provide a concise means of communicating a large amount of information about an individual's illness. The system focuses on the specific type, intensity, duration and effect of the various behaviours and symptoms in order to define and diagnose a clinical disorder (Fauman, 1994:2).

Barron (1998:6) and Huyssen (1999:11) mention that the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) was published due to the need for a consistent system to measure and diagnose behaviour. The *DSM-IV™ Multi Axial System* (2007) explains that the last major revision of the DSM was published in 1994 after a process of six years that involved more than 1000 individuals and numerous professional organizations. The DSM-IV-TR, was published in July 2000 because the next revision of the DSM, the DSM-V, will not be completed until 2013 or later (*DSM-IV™ Multi Axial System*, 2007). The DSM-IV-TR aimed to maintain the DSM-IV text and reflected the empirical literature up to 1992, confining the majority of the changes to the descriptive text. Some criteria sets changed in order to correct errors identified in DSM-IV

The researcher found that many social workers proclaim that it is unethical for a social worker to diagnose, while other social workers utilize a diagnostic system daily as a tool for their assessment. The *South African Mental Health Care Act* (Act 17 of 2002 section 1:xvii) clearly states that a mental health care practitioner is "a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care, treatment and rehabilitation services." The act contains no reference forbidding social workers to diagnose, although it clearly stipulates that social workers must be trained in mental health care. *The Policy Guidelines for Course of Conduct, Code of Ethics and the Rules for Social Workers* (South African Council for Social Service Professions [SACSSP], 2007a) also do not forbid social workers to diagnose. Sewpaul (2007) states that she is not aware of any legislation that specifically speaks of the use of the manual by social workers in South Africa. A controversy is

therefore evident regarding social workers' views, knowledge and ethical right to diagnose and to utilize the DSM system.

Du Toit (2002) states that social workers should always refer to a patient's mental wellness as: "a patient presents with a particular disorder" or "it seems that the patient might have a particular disorder". She concurs that social workers are not allowed to diagnose, and the patient must be referred to a clinical psychologist or psychiatrist for diagnosis. The researcher could not find any recent literature to support this; however, this statement is accepted as the truth by various social workers in practice (Gunter, 2004; Olivier, 2004; Pieterse, 2004; Smit, 2012).

Although Northen's *'Clinical Social Work'* was written in 1982, the source is still regarded as relevant in current practice. When a social worker, during the course of an assessment, suspects a physical disease, then a physician should make the diagnosis (Northen, 1982:74). Hence, the social worker should be alert to symptoms that suggest an illness. Concerning diagnosis of mental illness, the social worker needs to understand the meaning of the term and its possible implications for a particular social work service.

Whilst it may be believed that social workers are skilled in recognizing the major characteristics of mental dysfunctions, as classified by the American Psychiatric Association (APA), Northen (1982) referred to social workers in the United States. The researcher has a concern as to whether social workers in South Africa have the necessary skills to recognize the major characteristics of mental dysfunction. Gunter (2004), Pieterse (2004) and Smit (2012) stated that they had no official training in this field although they used the DSM due to pressure from their agencies (Keet, 2009:22).

Karpetis (2010:157) and Smit (2012) are in agreement with Northen (1982:74), who states that even in 1980 it was the social worker's responsibility to identify the problems in psychosocial relations and to suggest psychiatric assessment. The researcher raises the question: "How much training is included in the education of social workers regarding symptoms of socially related problems

versus psychologically related problems?" It is the researcher's opinion that these two problems are often interlinked, since social problems can trigger psychological conditions, while psychological conditions can trigger socially related problems.

Williams (1981) cited in Kutchins and Kirk (1995:160), a social worker and text editor of the DSM-III-R (the third revised edition), focuses on the use of the DSM in social work practice. She mentions that social workers may wonder why they should study the DSM system. Smit (2012) agrees with Williams (1981), cited in Kutchins and Kirk (1995:162), that there are three reasons why they should study the DSM system, namely:

i) The use of the DSM system will lead to improved treatment of individuals. Social workers in the mental health field are responsible for making diagnostic decisions and formulating their treatment plans according to the diagnosis. This is reason enough to be familiar with the system.

ii) Social workers must be able to communicate with their colleagues in order to maintain a position as a respected member of multi-disciplinary treatment teams.

iii) The DSM system can serve as a comprehensive educational tool for teaching about psychopathology and mental disorders.

Stromwall and Hurdle (2003:209) state that even though social work is the major provider of mental health services, social work literature pay little attention to psychiatric rehabilitation. Newman, Dannenfelser and Clemmons (2007:1044) state that only two studies of the use of the DSM in social work practice, namely Dziegielewski, Johnson and Webb (2002) and Kutchins and Kirk (1988:217), exist in published literature. These two studies provide limited information on the changing trends and reason for use of the DSM in social work practice. The researcher consulted and included information from both these two studies; however, they are not South African related studies. The researcher could not find any studies on the use of the DSM in social work practice in South Africa, emphasizing the need for research.

Gunter (2004), Pieterse (2004) and Smit (2012) state that social workers are expected to use the DSM system although no official training in this field has ever been offered to them. Sekudu (2007), Department of Social Work and Criminology, University of Pretoria, states that some academic institutions have a specialized Masters degree in Health Care, in which the DSM-IV is addressed when dealing with mental health. Carbonatto (2007), Department of Social Work and Criminology, University of Pretoria, mentions that undergraduate students in social work receive an introductory module in health and some mental health aspects, including psychiatric conditions and information on the DSM. The Play Therapy and EAP postgraduate courses in the Department of Social Work and Criminology, University of Pretoria, spend only one day on DSM training. Sekudu (2007) agrees with Carbonatto (2007) and states that the four-year degree does not prepare social workers to be mental health workers because the academic institutions merely introduce the concept of mental health to the students. Sekudu (2007) emphasizes that it is the social worker's responsibility to read more for a better understanding. The researcher is concerned that social workers without specific training in the DSM system will have limited knowledge, although they are expected to know of and utilize this system.

Basic knowledge and application of the DSM can be a tool in making a diagnostic social work impression that will enable the social worker to participate more effectively in a multi-professional team, make appropriate referrals and provide more insight into clients holistically. However, it is a concern should social workers utilize the DSM system in making diagnostic social work impressions without any constructive training in the DSM. This introductory section briefly touched on some of the problems with regard to the utilisation of the DSM-system by social workers in South Africa as identified by the researcher. The problem formulation receives attention in the following section.

1.2 PROBLEM FORMULATION

What is it about the topic that the researcher wants to find out? What is the area of interest for the study? Fouché and De Vos (2011:80) state that these

questions will guide a researcher in formulating a problem, since formulating the problem will not only focus the research, but also support a researcher in finalizing a research proposal.

Munson (2002:8) mentions that for the last two decades of the previous century, namely the 80's and 90's, social work practice was generally specialized by types of charity organizations, societies, settlements, youth services, child welfare services, hospitals and schools. Even in the twenty-first century, people and organizations in South Africa tend to combine the words 'social work' and 'welfare' as an unbreakable link. Through the years, distinctions were made based on whether service was rendered to an individual, a family or a group.

Mattaini and Kirk (1991:264) argue that, despite decades of interest by social workers, assessment remains an underdeveloped area in practice. All the controversies related to theoretical basis, purpose and technology have hampered efforts to develop consensus about the critical means of assessment. The authors (Mattaini & Kirk, 1991:261) further mention that the most widely used classification system among clinical social workers is the DSM system. The purpose of the DSM is as follows:

> The diagnoses in DSM are like ready-made suits that come in a variety of standard styles and sizes. They fit many patients well, others adequately and some barely at all. The clinician's task is to fit individuals with specific characteristics into standard, predefined categories (Fauman, 1994:1).

It is clear that social workers utilize the DSM-system. This, however, raises various concerns, focused on the following issues in order to formulate the research problem. These concerns are:

- o Are social workers qualified to do mental health diagnosis?
- o Are social workers already working with diagnostic tools?
- o What is the scope of practice for mental health social workers?

These problematic issues are briefly discussed below:

1.2.1 Are social workers qualified to do mental health diagnosis?

As from the 1990s, the issue of, "who is qualified to do mental diagnosis?" has been an on-going point of debate. In the USA, non-physicians can do a diagnosis, although some states require by law that only a physician or a psychologist can conduct a diagnosis (Munson, 2002:79). According to Strong (2007), very little South African research and few guidelines exist to who should be allowed to do mental health diagnosis. No legislation speaks of the use of the DSM system, or any other mental health assessment system by social workers in South Africa (Sewpaul, 2007). However, social workers are using the DSM system in their practice.

The South African Mental Health Care Act, 2002 (Act 17 of 2002 section 1:xvii) refers to a social worker as a mental health worker, if the social worker had adequate training, but makes no reference to the social worker's professional right to diagnose. Sewpaul (2007) states:

> The use and application of the DSM system is very, very specific and I can certainly understand concerns about its use with inadequate training and supervision. As a general principle, the social worker applies the manual with the supervision/guidance of a psychiatrist or if he/she is a specialist in the mental health field.

Karpetis (2010:157) states that social workers working in health care are defined as clinical social workers since this work focuses mainly on psychotherapy. Karpetis (2010:157) further defines clinical social work as "… a practice speciality in social work that build upon generic values, ethics, principles, practice methods, and the person-in-environment perspective".

Cooper and Lesser (2002:1) and Simpson, Williams and Segall (2007:4) refer to the definition by the *NASW Standards for the Practice of Clinical Social Work* (1989) that a clinical social worker aims to enhance and maintain the psychosocial functioning of individuals, families, and small groups, as do all social work practice. A clinical social worker utilizes social work theory and methods to treat and prevent psychosocial dysfunction, disability, or impairment that include emotional and mental disorders.

Northen (1982:300) and Simpson et al. (2007:4) emphasize that clinical social work encompasses a wide scope of developmental, preventative and therapeutic services. The acceptance of clinical practice within social work involved a process of development and acceptance before it was established for what it is known as at present.

Specific knowledge, theories and methods to assess and diagnose, plan treatment, to do intervention, and to evaluate outcomes of work with individuals, families and small groups are applied in the practice of clinical social work (Karpetis, 2010:157). Clinical social workers specifically focus on assessment of the bio-psychosocial dimensions of mental health disorders that influence the social functioning of clients (Karpetis, 2010:157). Clinical social work practice integrates the above with the objective of bringing about change in behaviours that will improve the individual's functioning and the relationship between people and their social environment.

Baumann (1998:439) emphasizes that in South Africa modern psychiatry must have a holistic approach to patient care whereby one assesses and manages an individual in a social world. The assessment must include the social context of the patient. Dziegielewski et al. (2002:28) declare that, in the mental health profession, social workers have to assist in the area of diagnostic evaluation and assessment. Assessment differs in a number of ways from diagnosis. Gambrill (1983:31) states that an assessment should be of value to the individual, based on the social worker's competence in helping people to define clearly their concerns and desired changes, and to identify related factors and possible means of attaining outcomes.

The researcher found from the literature above, that there are many uncertainties to whether a social worker could diagnose or not, and whether mental health is included or excluded from a social work assessment. The South African Mental Health Care Act (17 of 2002 section 1:xvii) indicates clearly that a mental health practitioner should have the adequate training,

which raises the question as to what type of training would be adequate. The question could then be raised, what is the meaning of diagnoses?

The South African Concise Oxford Dictionary (2006:320) explains *diagnosis* as the identification process for a problem or illness, after symptoms have been examined. Jutel (2010) defines diagnosis as follow:

> … providing a rationale for the consultation, confirming the authority and prestige of the medical profession, delegating the responsibility for labelling an illness, and in our contemporary era, providing access to a range of resources. The diagnosis is generally a prerequisite for treatment, an imperative for reimbursement, an authorization to deviate from expected behaviours, in sum, a legitimate force.

Gambrill (1983:33–34) alleges that the term *diagnosis* was borrowed from medicine, in which a physician makes a diagnosis of the patient's condition and then recommends treatment based upon this diagnosis. The DSM system describes a myriad of terms that professionals use to label individuals. The use of a diagnostic label often assumes a trait conception of behaviour in which consistency of behaviours across situations was assumed.

The following two sources indicate that social workers can diagnose. The standards for the classification of social work practice are based on four goals (Gibelman, 1995: xxii; Solomon, Shallar & Zimberg, 1993:245). One of these goals is "…to enhance problem solving, coping and developmental capacities of people. The functioning of such a goal is based on assessing, diagnosing, identifying, supporting, counselling and enabling". Terminology such as 'diagnosing' was used in the past as a function within social work practice.

In the United States, a 'licensed clinical social worker' is a social worker legally accredited by a state government to practice clinical social work in that state. Qualifications for the licence vary from state to state, but typically include an accredited school of social work, several years of supervised professional experience and successful completion of a social work licensing exam (Gibelman, 1995: xxvi). Petersen (2008) states that at the University of Cape Town (UCT) in South Africa a clinical social worker has to have a Clinical

Master's Degree in Social Work. UCT had a clinical master's programme even before 1975, and trained social workers and clinical social workers. The internship of clinical social work was similar to the psychology internship. While clinical social workers would focus more on intervention with families, the psychologists would do more testing, but both would do family, group and individual therapy. Everyone in the team had to be able to make a diagnosis and describe a psychodynamic formulation to explain the person's response to stressors, using a developmental theory, such as theories by Freud, Erikson and Klein. However, this may only have occurred in that specific school. In South Africa, a social worker is regarded as a clinical social worker based on the type of work done and not according to any formal licence or training.

The researcher identifies the first problematic issue as uncertainties as to whether a generically trained social worker is qualified to intervene with mental health or not. Some authors accept diagnosing as part of social work, while some do not. The next question focuses on social workers as mental health practitioners.

1.2.2 Are social workers working as mental health practitioners?

Where does social work link with the field of mental health? To what extent do social workers intervene with mental health?

Mental and behavioural health problems can be viewed as an overlapping cluster of problems. In the South African context, daily interactions take place between health related problems (e.g. heart diseases, depression and stress related conditions), social problems (e.g. child abuse, substance abuse and violence) and socio-economic problems (e.g. high unemployment, limited education and poverty). Baumann (1998:5) and Wilson, Lymbery, Ruch and Cooper (2008:575) suggest a comprehensive primary health care approach to the delivery of health care services that consists of three contexts, namely the physical context, the psychological context and the social and economic context that will dictate the presenting symptoms of an individual. It is therefore clear that there is a link between mental health and social work.

Stromwall and Hurdle (2003:211) suggest that social workers receive a more specific education programme with regard to the field of mental health, the perspectives and mental health terminology. The researcher explored the social work programmes at the universities of South Africa with regard to mental health as part of the curricula. Representatives from social work departments at the universities of Johannesburg (Van Breda, 2008), Cape Town (Addinall, 2011), Kwazulu Natal (Motloung, 2011), Pretoria (Carbonatto, 2007) and Free State (Reyneke, 2008) stated that they provide limited training in mental health on an undergraduate level. The majority of representatives consulted were of the opinion that mental health is a specialised area, which should receive attention on a postgraduate level.

Sands (1991:6) and Starnino (2009:820) make the concerning contradicting statement that social workers provide the bulk of mental health services. The researcher is of the opinion that the problem lies with social workers providing the service, irrespective of their training or lack thereof in the DSM or any other mental health system.

Dziegielewski et al. (2002:37–38) declare that knowledge of diagnostic impressions and criteria can assist the social worker to impact on and enhance the individual's overall level of functioning. Social workers often have regular and subsequent contacts with their clients and therefore can be essential in assisting the multi-professional team to re-examine and/or re-formulate previous diagnostic impressions. Treating an individual is a team effort and social workers are aware of the importance of building and maintaining a therapeutic rapport with the individual. A single therapeutic language of diagnostic terminology amongst this team will make the input, especially from the social worker, an essential contribution to intervention effectiveness.

The researcher concludes that some literature indicate that social workers are already doing mental health assessments, and that some authors even note that social workers can diagnose. However, it seems that training and education with regard to mental health and mental health assessments in South Africa are

limited. This raises the question: What is the scope of practice for social workers in mental health?

1.2.3   What is the scope of practice for mental health social workers?

Sartor (2008), Executive officer of the South African Association of Social Workers in Private Practice (SAASWIPP), states that the association compiles a scope of practice for social workers, in the lack thereof, addressing the role of social workers in mental health. However, she also notes that the finalization of a scope of practice will be a lengthy process, since changes will have to be made in the Social Service Professions Act 110 of 1978. In the absence of a finalized scope of practice for social workers in mental health, the researcher explored the views of various authors with regard to the role of mental health social work.

The researcher observed that social workers have to diagnose, regardless of whether they have had sufficient training in a diagnostic system or not. From her own working experience, the researcher agrees with Munson (2002:79), who mentions that during the 1990s agencies forced mental health professionals to enter a DSM diagnosis in their database reports. Gunter (2004) and Pieterse (2004) concur by stating that, although they received weekly supervision from peers, they had to utilize the DSM system in South Africa without formal training as part of their agencies' service requirements (Keet, 2009:22). Using the DSM system without training may lead to uncertainty and negativism towards the manual amongst non-trained professionals. Despite this, by 1994 the DSM was the most widely used diagnostic system in mental health (Allers, 2008; Collin, 2008; Garb, 1998:39; Huyssen, 1999:11; Munson, 2002:80).

Although the DSM is the classification system for mental disorders used most often in South Africa, the researcher is of the opinion that not all social workers in South Africa are familiar with and comfortable with the system. Dziegielewski et al. (2002:30) are of the same opinion as Huyssen (1999:11); they declare that little empirical evidence exists concerning social workers' knowledge of the

DSM system and limited recent data is available on the attitudes of social workers towards its use in interviews and in social work practice.

The question arises as to whether diagnostic interviewing is part of the social worker's scope of practice. Diagnostic interviewing refers to discussions with an individual and the establishment of a working diagnosis that can serve as the basis for an initial plan for treatment. Skodol (1989: xv, 1) defines the word diagnosis as follows: "The art of distinguishing one disease from another – the determinations of the nature of a case of disease." According to Skodol (1989:2), the purpose of a diagnostic interview is to:

- gather information necessary for making a DSM multi-axial diagnostic assessment;
- form a cooperative alliance with individuals, and
- form a therapeutic environment where individuals would feel understood by an empathic interviewer.

It is clear from the discussion above that social workers are involved in and committing themselves to diagnostic interviewing.

Phares (1992:5) refers to studies by the American Psychiatric Association (APA) that showed clinical social workers to be the fastest growing psychosocial profession in the USA between 1975 and 1990. In Table 1, Munson (2002:8–9) highlights the basis of primary social work practice areas in the USA, based on statistics of the National Association of Social Work (NASW).

Table 1:   Primary practice areas of working NASW members in the USA

Primary Practice Area	1988		1991	
	N	%	N	%
Children	11,165	16.3	14,256	16.3
Community organization-planning	913	1.3	976	1.1
Family services	8,422	12.3	9,860	11.3
Corrections	899	1.3	1,025	1.2
Group services	351	0.5	399	0.5
Medical clinics	9,005	13.2	10,926	12.5
Mental Health	21,431	31.3	28,545	32.7
Public assistance	613	0.9	695	0.8
School Social Work	2,918	4.3	4,083	4.7
Aged	3,227	4.7	3,970	4.5
Substance Abuse	2,731	4.0	4,031	4.6
Mental-developmental disabilities	2,038	3.0	2,356	2.7
Other disabilities	364	0.5	460	0.5
Occupational social work	527	0.8	711	0.8
Combined	3,339	4.9	4,836	5.5
Other	522	0.8	136	0.2
Total Respondents	**68,465**		**87,265**	

Munson (2002:8) states that there was a significant increase in the percentage of social workers in private practice from 10.9% in 1982, to 16.1% in 1990, and a further increase to 19.7% by 1995. It is significant that the highest percentage for a practice area is in the field of mental health. Although the statistics are not recent, it is clear in the table above that the number of social workers in private practice increased as well as the number of social workers working in mental health.

On a national level, South Africa also shows a growing population of social workers in private practice. The researcher approached the South African Association for Social Workers in Private Practice numerous times for recent statistics; the most recent statistics were published in 2007 and refer to 2003

when there were 1127 registered social workers with SAASWIPP (*South African Association for Social Workers in Private Practice,* 2007b). Table 2 shows their geographical distribution.

Table 2: SAASWIPP members' geographical distribution for 2003

Province	N	%
Eastern Cape	48	4
Free State	44	4
Gauteng	504	45
Kwa-Zulu Natal	142	13
Limpopo Province	67	6
Mpumalanga	35	3
Northern Cape	11	1
North West Province	27	2
Western Cape	249	22
Total	**1 127**	**100**

N=Frequency

The researcher was unable to find any data on how many of these practitioners were in mental health. If South Africa would have the same trend as in the USA (as indicated in Table 1), it would be very concerning, since there is no clarity on the scope of practice in this regard, although social workers practice in the field of mental health.

From the above, the researcher concludes that the problematic areas are the shortfall of a mental health social work scope of practice; the concern that social workers assess and even diagnose in the field of mental health without adequate training, and the need for training in mental health and mental health diagnostic systems.

Based on this problem formulation, the researcher compiled the following goal and objectives.

1.3 PURPOSE, GOAL AND OBJECTIVES OF THE STUDY

A specific purpose, goal and objectives are necessary to guide the researcher through the research processes. A purpose statement includes the intent of the study and not the problem or issue that leads the researcher to the need for the specific study (Creswell, 2011:111). Durrheim (2006:40) stresses that the researcher should ask him/herself three questions regarding the purpose of the study: "…what are the units of analysis, what information do you require about these units and what type of study is best suited to answering the research questions?"

1.3.1 Goal

Fouché and De Vos (2011:94) describe the meaning of 'goal' as "the broader more abstract conception of 'something which you plan to do or achieve'". Durrheim (2006:40) refers to the research goal as the process through which the purpose of a specific research is defined by asking two questions: Who or what do you want to draw conclusions about? What type of conclusions do you want to draw about your object of analysis?

The goal for this study is formulated as: To develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system, namely the DSM system, when dealing with individuals who present with a specific disorder.

1.3.2 Objectives

According to Fouché and De Vos (2011:94), the objectives should be specific, clear and achievable. Durrheim (2006:41) states that there are typically two aspects of the objectives worth defining, namely the units of analysis that are the focus of investigation and the variables, which are features of the objectives that are to be observed or measured. Objectives refer to those more specific changes in the programmes, policies or practices believed to contribute to the broader goal.

The study was guided by the following objectives:
- To do a literature study regarding social workers' diagnosis and assessment within the context of the DSM system
- To explore social workers' views and utilization of the DSM system
- To develop a training programme and train social workers in the utilization of the DSM
- To implement the developed training programme for social workers in the utilization of the DSM
- To measure the effectiveness of the content of the training programme
- To draw conclusions and make recommendations with regard to the benefit for the social work profession as well as to multi-professional teamwork, should social workers receive training in the DSM system

The researcher conducted the research study and analysed the research results within a South African context.

1.4 RESEARCH HYPOTHESIS FOR THE STUDY

Neuman (2011:18) asserts that a topic is often too broad for actually conducting a study. A study must be narrow to focus on a specific research question that a study can address and often this requires developing hypotheses. As discussed in the section on problem formulation, the researcher focused the study, prior to developing the hypothesis, by asking the following questions:
- Are social workers qualified to do mental health diagnosis?
- Are social workers already working with diagnostic tools?
- What is the scope of practice for mental health social workers?

In all these questions, the researcher is of the opinion that there are uncertainties and lack of clarity. Based on the above, the researcher developed a hypothesis. A hypothesis is a tentative, concrete and testable statement about relations among variables. A hypothesis suggested as an answer to a problem has to be tested empirically before it can be accepted and incorporated into a

theory. Babbie (2011:46) states that to test a hypothesis, a researcher must specify the meanings of all the variables involved. De Vos and Strydom (2011a:35) and Wienclaw (2009:2) simplify this by stating that a hypothesis asks, "Is this so?"

The researcher utilised the discussion above with regard to the development of a hypothesis:

Problem: There are uncertainties in the social work profession as to whether social workers are qualified to diagnose, regarded as an integral task in mental health intervention. The question arises as to whether social workers are qualified to work in the mental health field. The answer could be provided in a scope of practice for social workers in South Africa, but such a scope is still in a formulizing process. Social workers are working in the field of mental health, regardless of their training, qualifications and knowledge of either mental health or mental health diagnostic systems, such as the DSM. This aspect causes more uncertainties in the field of mental health, amongst social workers (clinical vs. generic social workers) and other professions, with regard to the quality and role of social work services.

Answer: If social workers are already utilizing a diagnostic system, in this case the DSM system, regardless of training, education, qualifications or knowledge thereof, a training programme should be developed to equip them with the required knowledge and insight with regard to their mental health clients. This could assist in enhancing the social work profession since social workers working in the field of mental health will have insight into the mental health terminology and pathology.

Empirical research: The researcher proposes the first four phases of intervention research in order to test the hypothesis.

In view of the preceding statement of the problem, the following overarching hypothesis directs this research:

If social workers receive formal training in the utilization of the DSM system, it will equip them with knowledge and insight with regard to assessing mental health clients.

This may enhance the profession, since social workers will be able to participate in the multi-professional team with insight with regard to mental health terminology and assessments.

1.5 ETHICAL ASPECTS

The researcher is responsible to consider all ethical aspects while planning a research study. Research ethics focus on the welfare of research participants as well as scientific misconduct and plagiarism. Wassenaar (2006:63) claims, "Many of the major ethical guidelines for researchers were developed because of specific abuses of research participants. Although the worst of these were in biomedical studies, psychosocial research has also involved abuse of research participants".

This research study adhered to the aspects of ethical research as discussed in Babbie (2011:477), Neuman (2011:143), Stalker, Carpenter, Connors and Phillips (2004:377–383), Strydom (2011:115) and Wassenaar (2006:68) who refer to the following aspects of research ethics.

1.5.1   Avoidance of harm

All the possible physical, psychological and legal risks were assessed. Harm and 'costs' of the research to the participants were carefully identified, and as far as possible such risks and costs were minimized so that the benefit ratio was favourable (Neuman, 2011:145-146; Strydom, 2011:115-116; Wassenaar 2006:71).

The researcher is of the opinion that the risk for emotional harm of participants was limited since the research topic/theme is not a personal relationship or personal issue being exposed. The researcher was alert at all times for any

harm that could occur and was aware that often when people see all the diagnostic criteria in the DSM system, they tend to screen either themselves or close relatives according to these criteria. Possible emotional turmoil was avoided since the researcher addressed this concern in the introduction, and reminded the participants that the DSM system is only a tool in the field of mental health and cannot by itself make a diagnosis. During the course of the two-day training, the researcher also took informal reports from participants on a regular basis to ensure that they were not experiencing any harm. The researcher further provided her own phone number as a contact should they feel that participating in the study had caused any form of harm, pain or uncertainties (Babbie, 2011:479-480).

1.5.2 Informed consent

Historically, informed consent was seen as the only determinant of the ethicality of research. According to Neuman (2011:149) and Babbie (2011:481) the standard components of consent are:

- Provision of appropriate information, such as the purpose and procedure of the research: The researcher included the purpose of the research study in the training invitation and discussed the purpose with procedures as part of the introduction on the first day of the training.

- Participants' competence and understanding with a statement of any risks or discomfort associated with participation: The researcher informed participants that they were welcome to raise any discomfort at any time during the training.

- A guarantee of anonymity and confidentiality of records: Although the researcher presented the training and met the respondents, they did not have to attach their names to any research document, ensuring anonymity. The researcher assured all respondents of confidentiality, both verbally and in the letter of informed consent.

- Voluntary participation and the freedom to decline or withdraw after the study started: The researcher stated the above in the letter of informed consent and verbally repeated the information at the training.

- A statement of any benefits or compensation provided to participants and the number of subjects involved: This was not applicable in the study.

Formalization of consent must usually be in writing. The researcher ensured that all the respondents gave written consent. Wassenaar (2006:77) and Stalker et al. (2004:379) conclude by stating that researchers enjoy a great amount of power to sway public and professional opinions and that these powers must be exercised responsibly and with sensitivity to the welfare and rights of research respondents. The respondents signed an informed consent form for the release of all information gathered in this study.

1.5.3   Cooperation with contributors

Research projects are often so expensive and comprehensive that the researcher cannot finance the project (Strydom, 2011:124). The researcher is fortunate to work for a group of mental health clinics, The Life Path Health Group, which not only supports her study in this field, but also contributed, with a sponsorship for the venue and beverages. The researcher is a member of the South African Association of Social Workers in Private Practice. This association distributes a list to their members of all the social workers in private practice, and the researcher therefore had automatic access to the list in order to invite respondents.

1.5.4   Deception of respondents

The researcher had to identify and address questions that may be a concern for the target group. The population in this study was social workers dealing with and assessing clients in the Western Cape. This population was informed of possible benefits (both direct and indirect) should they receive the training. The aim of an intervention is to add value to a participant's clinical practice (Wassenaar, 2006:69). Strydom (2011:118) emphasises that researchers should not withhold any information from the respondent. Deception takes place when the researcher intentionally misleads subjects by way of written or verbal instructions. The researcher therefore detailed the goal of the study, the actions

of the respondents and discussed possible experiences that the subjects could go through.

1.5.5 Actions and competence of the researcher

A researcher is ethically obliged to ensure that he/she is competent and adequately skilled to undertake the proposed investigation. Strydom (2011:123) and Wassenaar (2006:70) state that a poor research design is an ethical issue because it can lead to invalid results and unnecessary waste of resources and participants' time. With regard to knowledge of and experience of the DSM system, the researcher had to utilize the DSM-IV as a work requirement without any formal training. Moreover, she had to work with this system in the United Kingdom. The researcher is skilled in facilitating training sessions, since facilitation has been part of her duties over the last ten years. She is also fortunate to work in a psychiatric institution with exposure to information, experts and resources in this field of study.

The competence of the researcher that will undertake the study is also an important component of this ethical element. The researcher is an experienced social worker and researcher. The study was conducted under the supervision of an experienced study leader.

1.5.6 Release or publication of the findings

The findings of the study must be introduced to the reading public in written format or the study will mean very little and not be viewed as research (Strydom, 2011:126). The researcher compiled an objective and as accurate as possible research report and clearly reported the shortcomings and limitations in the study. She informed the subjects of the findings in an objective manner, as recommended by Strydom (2011:126), by presenting a feedback session for the respondents who were interested in the outcome of the study. The researcher presented and discussed findings in informal discussions.

1.5.7 Privacy, confidentiality and anonymity

Neuman (2011:152) and Strydom (2011:119) state that when dealing with ethical aspects in research, violation of privacy, the right to self-determination and confidentiality can be viewed as being synonymous. Privacy implies that personal information will be kept confidential. Information given anonymously ensures the privacy of the respondent. The respondents were assured of privacy, confidentiality and anonymity, and no references were made to any respondent in the first person. Each respondent signed a letter of informed consent, which indicated that all the personal details would stay confidential.

The researcher is of opinion that all the important ethical aspects received attention. The following main concepts need clarification.

1.6 DEFINITION OF MAIN CONCEPTS

1.6.1 Mental health practitioner

Kerr, Dent-Brown and Parry (2007:64) explain that a mental health team member varies from different locations and settings, but can offer a wide range of services including mental health assessments, treatment of and management to disturbed and distressed patients. *The South African Mental Health Care Act* (17 of 2002 section 1:xvii) clearly states that a mental health care practitioner is a psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker trained to provide prescribed mental health care, treatment and rehabilitation services. In the context of this study, a mental health practitioner is not only a professional with skills in dealing with mental health issues, but also a professional that received specialized training in mental health care.

1.6.2 DSM

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health professionals

in the United States (*DSM-IV™ Multi Axial System*, 2007). The DSM applies to a wide array of contexts. Clinicians and researchers of different orientations such as biological, psychodynamic, cognitive, behavioural, interpersonal, and family/systems use the DSM. The DSM-IV was designed for utilization in inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care settings. The DSM-IV is applicable for use with community populations, by psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counsellors, and other health and mental health professionals and is a tool for collecting and communicating accurate public health statistics (*DSM-IV™ Multi Axial System*, 2007).

The Diagnostic Statistical Model is a multi-axial system consisting of five axes with each axis referring to a different area of information. The concept of multi-axial diagnosis originates from the psychiatrists, Essen-Möller and Wohlfahrt, who used it briefly in Denmark in 1947 as part of their national classification of mental disorders (Skodol, 1989:39). Since then, several multi-axial systems have been proposed, but none has been as comprehensive as the DSM multi-axial system, regarded as a major advance in the psychiatric field.

The DSM is, therefore a guideline for clinicians to identify certain signs and symptoms in a client in order to make a psychiatric diagnosis. The main function of a psychiatric diagnosis is to provide a concise means of communicating a large amount of information about a patient's illness.

1.6.3 Training

Public Relations and Communication Management [sa] provide the following definition for training: "Training is any activity that is undertaken with the specific aim of acquiring or improving relations, communication and/or business skills necessary to function effectively at work." The *South African Concise Oxford Dictionary* (2006:1244) states that to train an individual means to teach that individual a particular skill or behaviour. The researcher is of the opinion that training in this study refers to providing an opportunity for social workers to acquire and improve their skills and communication.

1.6.4   Training programme

The *South African Concise Oxford Dictionary* (2006:932) defines a programme as a set of related measures or activities with a long-term aim. Atkinson (2001) provides the following definition for a programme:

> It is suggested that the reference to 'programme' … will require at least the basic information of a list of verbal descriptions of activities or operations together with a list of dates for commencement and completion of each activity. The extent of the list of activities will depend upon the description of the programme.

The researcher defines a training programme as a time-limited programme specifically developed to train people in an area where they lack knowledge and skills.

1.6.5   Clinical social worker

A clinical social worker is a social worker that maintains and enhances the psychosocial functioning of individuals, disability, or impairment including emotional and mental disorders and is based on knowledge of one or more theories of human development within a psychosocial context (Cooper & Lesser, 2002:1; Simpson et al., 2007:4). Horejsi, Horejsi and Sheafor (1997:61) state that a clinical social worker is a social worker with significant functions that include the role of conducting psychosocial assessments and diagnosis.

In the context of this study, the researcher defines a clinical social worker as a qualified social worker that provides mental health services for the prevention, diagnosis, and treatment of mental, behavioural, and emotional disorders in individuals, families, and groups.

1.7 LIMITATIONS OF THE STUDY

- After an extensive search in collaboration with the subject specialist for Social Work in the University of Pretoria library, the researcher concluded

that there is limited literature and research regarding this field of study. The literature found was mostly applicable in the United States, an indication that there is a real need for research, information and training in this field within the South African context.

- Respondents were of the opinion that the training programme should have taken place over more than two days; however, most of the respondents also mentioned that they have limited time available and acknowledged that it would be difficult to take more time out of their schedules.

- The uncertainty within the South African situation regarding the distinction between a general social worker and a clinical social worker is still a limitation and frustration for many professionals.

- The lack of a formal scope of practice for social workers in South Africa is a huge limitation. Currently, various bodies strive to formalize a national accepted scope of practice. This had an impact on contextualising the study.

- The researcher accepts that the evaluation of this intervention could have been done more extensively. This research study therefore provides a platform for further training and intervention, as dictated by the intervention research design.

- More instruments should be used to measure 'knowledge and insight with regard to mental health'. The researcher is of opinion that due to the lack of previous research, it has been difficult to narrow aims, objectives and the hypothesis, prior to the study. However, the study has indicated that there is a definite need for further research in this field.

1.8 FRAMEWORK OF THE RESEARCH REPORT

The research report consists of six chapters, as shown in Diagram 1:

Diagram 1:   Framework of research report

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┌─────────────────────────────────────┐
│        RESEARCH REPORT               │
└─────────────────────────────────────┘
        ┌──────────────────────────────────────┐
        │  CHAPTER 1                            │
        │  General Introduction                 │
        └──────────────────────────────────────┘
        ┌──────────────────────────────────────┐
        │  CHAPTER 2                            │
        │  Social Work in Mental Health         │
        └──────────────────────────────────────┘
        ┌──────────────────────────────────────┐
        │  CHAPTER 3                            │
        │  DSM System                           │
        └──────────────────────────────────────┘
        ┌──────────────────────────────────────┐
        │  CHAPTER 4                            │
        │  Research Methodology                 │
        └──────────────────────────────────────┘
        ┌──────────────────────────────────────┐
        │  CHAPTER 5                            │
        │  Empirical study, data analysis and   │
        │  interpretation                       │
        └──────────────────────────────────────┘
        ┌──────────────────────────────────────┐
        │  CHAPTER 6                            │
        │  Summary, conclusions and recommendations │
        └──────────────────────────────────────┘
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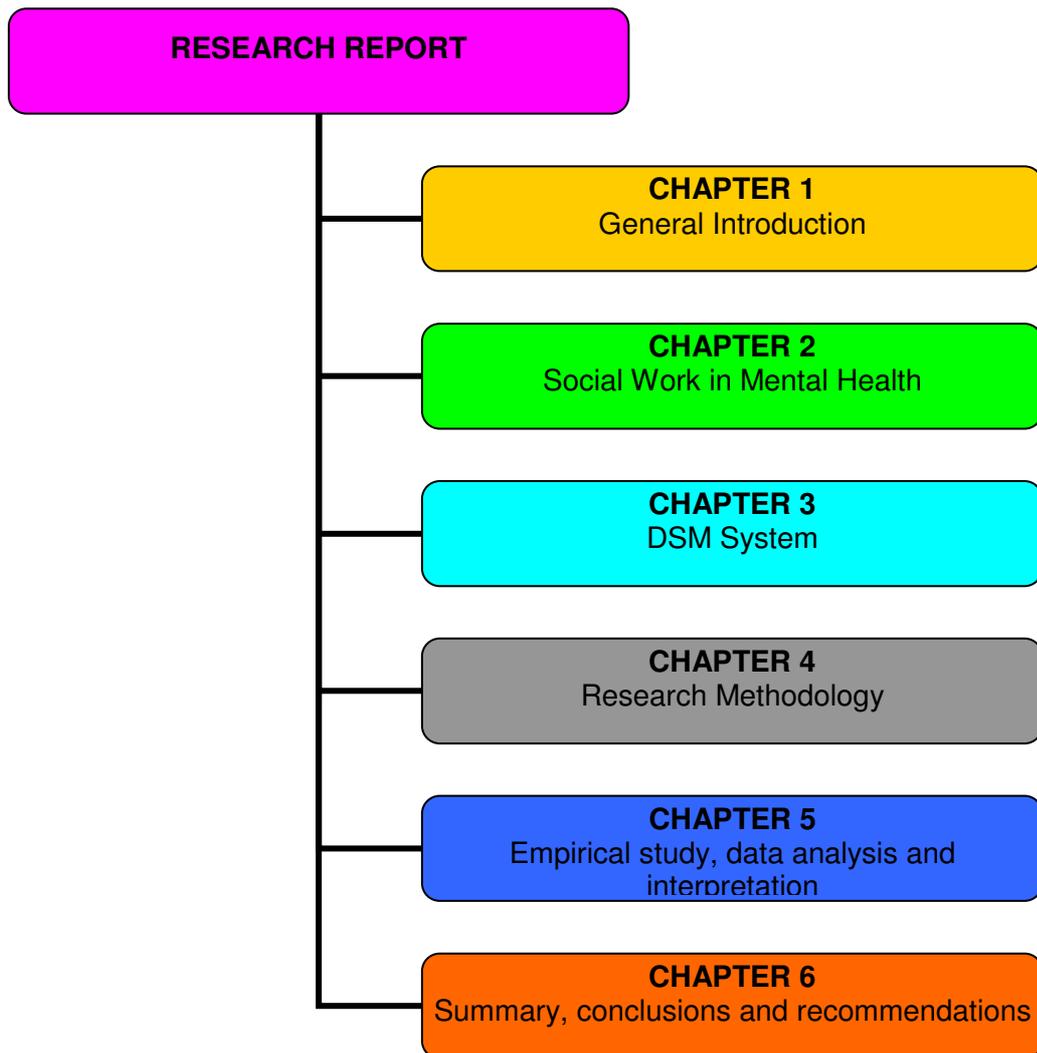
1.9 SUMMARY

The researcher paid attention to the current utilization of the DSM system by social workers and highlighted various views. It is clear from the discussion that social workers are using the DSM system without training.

The research problem was formulated based on social workers admitting that they are using the DSM system, regardless of their training or lack of training in the DSM system. Social workers do not receive training in any mental health diagnostic system while receiving their formal education.

The goal for this study is the development, implementation and pilot testing of a programme to train social workers in the utilization of an accredited diagnostic

system, namely the DSM system, when dealing with individuals who present with a specific disorder.

The hypothesis that directed this research indicated that if social workers receive formal training in the utilization of the DSM system, it would equip them with knowledge and insight with regard to the mental health assessments of their clients. This could enhance the profession, since social workers would be able to participate in the multi-professional team with insight with regard to mental health terminology and assessments.

The researcher addressed various ethical aspects such as the avoidance of harm, obtaining informed consent, ensuring cooperation with contributors, avoiding any deception of the respondents, ensuring competence from the researcher's side and focusing on the privacy, confidentiality and anonymity of the respondents.

The limitations of this study were the lack of literature, the need for training over a longer period, the uncertainties regarding the practical definition of 'clinical social work' and the need for a national accepted scope of practice for social workers. The researcher confirms that the evaluation of this intervention could have been done more extensively. This research study therefore provides a platform for further training and intervention, as dictated by the intervention research design. More instruments should be used to measure 'knowledge and insight with regard to mental health'. The researcher is of opinion that due to the lack of previous research, it has been difficult to narrow aims, objectives and the hypothesis, prior to the study. However, the study has indicated that there is a definite need for further research in this field.

CHAPTER 2

SOCIAL WORK IN MENTAL HEALTH: THE SOUTH AFRICAN CONTEXT

2.1 INTRODUCTION

Poverty, political turmoil and violence in South Africa are an enormous additional burden to mental health and the social wellbeing of the South African citizen. Biological, psychological and developmental factors in the history of an individual as well as social and economic factors, affect mental health (Wilson et al., 2008:576). The system of apartheid with forced removals, migrant labour, the disintegration of families and interpersonal violence as consequences, was and remains a cause of psychosocial distress. The distress does not necessarily indicate psychiatric illness, but causes suffering and impairs functioning. Seedat, Williams, Herman, Moomal, Williams, Jackson, Myer and Stein (2009:346) clearly state their view on mental health in South Africa:

> South Africa has a legacy of racially inequitable, fragmented and inadequately resourced mental health care services, characterised by provincial variability. No systematic data exist on the current use of health services for the mentally ill, or the nature and extent of unmet treatment needs.

The statement above could perhaps explain why the researcher found that more and more social workers deal with a client load that includes various mental health disorders, sometimes-overlapping disorders, and patients who are using prescribed psychotropic medication also noted as trends in the United States (Farmer, Bentley & Walsh, 2006:1). Some social workers therefore need to base their assessments of clients on mental health diagnostic criteria. In order to support and assist social workers to deal with their clientele even more efficiently, awareness of and training in the utilization of a mental health diagnostic system, such as the DSM-IV-TR, could empower not only the social worker but also the entire profession. However, it seems that various societies, groups and individuals have questioned the role of

social workers in mental health. It further seems that, on international level, social workers are divided in their opinions with regard to the DSM system. They either support DSM utilization or are against the DSM model with various arguments to substantiate their views. The researcher explains the reason for focussing on the DSM system in particular later in the introduction of Chapter 3.

In South Africa, as in many other countries, questions and controversial issues arise when the social work profession in mental health is examined. Are social workers adequately trained to intervene diagnostically? Is there any need for a social worker to know or use a diagnostic model? Are social workers recognized as mental health team members? What is the scope of practice for social workers in the mental health discipline? The answers to these questions are very important in order to assess the need and value of a training programme for social workers in a mental health diagnostic model. If all these controversial issues pertaining to the social worker in mental health could be explored, the profession would have better insight into the diversity of views when comparing the appraisals and criticisms of the DSM model.

In the light of all the conflicting perceptions pertaining to social work as a professional practice in mental health, it is important to address the concerns, in order to assess the need and relevance for social work training in a mental health diagnostic system. In this chapter, there will be a focus on clarifying the following:

- The role of social workers in mental health with regard to:
    - clinical social work as well as
    - the different social work roles within the private vs. public sector
- The role of the mental health team with specific reference to the psychiatrist, general practitioner, occupational therapist, psychiatric nurse, psychologist and social worker
- Social work qualifications in mental health
- Social work methods and approaches in mental health

2.2 THE ROLE OF SOCIAL WORK IN MENTAL HEALTH

The question could be asked of where the role of social work links with mental health. The researcher is of the opinion that many psychiatric illnesses pass unrecognized by general practitioners, and a minority of cases are referred to psychiatric services. All social workers, whatever their speciality, will encounter the mentally ill among their general caseload. Aviram (1997:2) confirms this point of view and notes that the history of social work involvement in the field of mental health goes back to the early period of the profession, namely in the last years of the 19th century.

Thirty years ago, a child psychiatrist would see a problematic child individually and a social workers' role would be to intervene with the parents, with little attention to the family as a whole (Bower, 2010:171). The author emphasises that the social worker's role in mental health has changed over the years where the family perspective became more significant. Part of this change was also the development of clinical social work.

2.2.1   Clinical social work

Cooper and Lesser (2002:1) and Simpson et al. (2007:4) concur with Sands (1991:2), that one of the particular changes in social work is where social workers for whom psychotherapy represents a significant method of intervention, are referred to as clinical social workers. Like psychotherapists of related disciplines, clinical social workers use the face-to-face professional relationship to promote awareness, change, growth, and improved psychological functioning in individuals, families, and groups.

Clinical social workers view clients and their problems in relation to the multiple contexts in which problems occur and pursue interventions that focus on clients' social and political environments as well as the psychological and interpersonal domains. Simpson et al. (2007:4) concur with Cooper and Lesser (2002:1) who state that clinical social work practice is the professional application of social work theory and methods to the treatment and prevention

of psychosocial dysfunction, disability, or impairment including emotional and mental disorders and is based on knowledge of one or more theories of human development within a psychosocial context.

From the literature review it seems that the role of clinical social work and social work have some overlapping areas; clinical social workers focus more on psychotherapy, while generically trained social workers make use of integrated methods and interventions. DuBois et al. (2009:10) mention that generalist social workers know the interconnectedness of personal and collective issues. Because of the interconnectedness, they work towards change that will benefit human system functioning within a variety of human systems, societies, communities, neighbourhoods, complex organisations, formal groups, families and individuals. The Clinical Social Work Interest Group (Rogers, 2008) believes that although generalist social workers should be allowed to use generalist diagnostic codes, clinically trained social workers should be the only social workers allowed to use the codes used by clinical psychologists, because of the specific diagnostic and therapeutic training. Rogers (2008) explains that part of their clinical social work training ironically results in avoiding using labelling and the resultant use of diagnostic codes.

However, it is clear that generically trained social workers play a role in mental health (Newman et al., 2007:1044; Stormall & Hurdle, 2003:209). Mental health is an integral part of health care, but there are important differences (Gunn & Blount, 2009:236) such as social workers that are employed in a variety of settings, such as mental hospitals, day treatment centres, child guidance clinics, community mental health centres, and residential treatment facilities (Northen, 1995:22; Sands, 1991:6). Ironically, Northen (1995:22), Sands (1991:6) and Starnino (2009:820) agree that social workers provide the bulk of mental health services and that the types and causes of mental disorders and treatment options (with special emphasis on the psychosocial factors) are all connected with a mental disorder. The question then remains, what is the role of social workers in the mental health sector? In order to clarify the social worker's role, the researcher first needs to focus on the mental health sector where a social worker must fulfil her/his role.

2.2.2 Role according to mental health sector

The researcher found that internationally, social work in mental health is divided into a public sector and private sector. The debate over the relationship between public services and the private sector is not a new one. In the case of health, it is one of the the biggest unresolved issues, not only in the United Kingdom (Hinchliffe, 2001:5), or in the United States of America (Block & Grosser, 1983:245) and Canada (*Canadian Association of Social Work*, 2009), but also in South Africa. In South Africa, Leon and Mabope (2005:33) indicate that over the last 10 years, significant attention has been given to the relationship between government and the private health sector. One of the main challenges in the South African context is that the health spending between private and public has widened, where the public sector serves 84% of the South African population, while the private sector serves less than 20% of the population. However, Leon and Mabope (2005:33) note that the private sector has almost seven times more spending per capita than the public sector.

In reality, it seems that due to financial and resource constraints, the majority of people must sometimes wait unconscionable lengths of time to see a consultant in the public sector. The minority who can afford services can visit the same consultant in private practice. Treatment for individuals, who can pay more than those with the greater clinical need, is an ethically debated issue that emphasises the reality of the distortion of priorities. Many countries have used the private sector to make up for alleged shortcomings in the public sector, with consequences (*Canadian Association of Social Work*, 2009; Hinchliffe, 2001:5; Simpson, Emmerson, Frost & Powell, 2005:88). These statements are also true for the South African context (Leon & Mabope, 2005:40).

Hinchliffe (2001:6) emphasises that the private sector has an obligation towards investors. Social obligation to customers is not the priority of the

private sector. However, the motivation of the public sector is for social responsibility and environmental awareness.

These two goals may explain the difference in the role of social work in these two sectors in mental health. Within the goals stated above, the social worker's role in the private sector is much smaller, although social workers are often on lower income scales compared to other health professionals, such as the general practitioner or psychiatrist. One of the main obligations in the private sector is towards investors, and not social responsibility. On the other hand, the researcher has observed how social workers in the public sector often fulfil the leading role in intervention with mental health patients (Starnino, 2009:820). The researcher is of the opinion that this may be due to the high volume of clientele, shortness of professional staff, and affordability of social workers within the public sector. The mental health sector in which a social worker operates often dictates the role of the social worker. Regardless, there are also some theoretical dictations towards the role of social work.

According to Allers (2008), the South African Society of Psychiatrists (SASOP) is not in a position to include the social work profession as a therapeutic service within their psychiatric guidelines for private mental health patients, due to a lack of a formal recognized scope of practice for social workers in South Africa. This would imply that in the South African health sector no medical aid would accept any claims from the mental health benefits for therapeutic services provided to a private mental health patient by a social worker, although the medical aids' day-to-day benefits may cover some social work services (Dittmer, 2011; Pridigeon, 2011). Allers (2008) states that SASOP approached the South African Council for Social Service Professions (SACSSP) on various occasions in a quest for the scope of practice for social workers, but had no results.

However, *the South African Mental Health Care Act* (17 of 2002 section 1:xvii) states that a mental health care practitioner is: "A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker who has been trained to provide prescribed mental health care,

treatment and rehabilitation services". Duncan (2008), who represents the Clinical Social Work Interest Group, argues that "generically trained social workers are out of their depth" in mental health multi-disciplinary teams and that only clinical social workers are trained to operate in mental health institutions and with mental health issues.

Rogers (2008) and Sartor (2008) agree that the South African Council for Social Service Professions and the South African Association of Social Workers in Private Practice (SAASWIPP) do not recognize clinical social work as a separate specialized form of social work. They rather acknowledge clinical social work academically as a speciality field for a postgraduate qualification in Social Work, similar to any other specialized Master's degree. Sartor (2008), Executive Officer for the South African Association of Social Workers in Private Practice (SAASWIPP), states that they started to compile a scope of practice in order to address these issues, but have not formalized a final concept yet. The researcher is of opinion that such a scope of practice could change the role of social work in the private sector significantly, since the key role players, SASOP, requested it. However, Sartor (2008) emphasizes that changes in the scope of practice for social work (with regard to mental health) will be a lengthy process, since the changes have to be made in a legislative process, and should be noted in the Social Service Professions Act.

The researcher shares the concern of SAASWIPP about the disregard shown to the value-adding role and contribution of social workers, should there be no recognition for the role that social workers play in mental health (Sartor, 2008).

The Clinical Social Work Interest Group (Rogers, 2008) is of the opinion that mental health is a specialized field, wherein they, as Clinical Social Workers, have adequate training to intervene. According to this group, the role for social workers in mental health is mainly the speciality field of clinical social workers. Rogers (2008) admits that this opinion is their sole view, and that the South African Association of Social Workers in Private Practice (SAASWIPP) still

differs, stating that all social workers already have the required training to play a role in mental health and have diagnostic skills for using mental health diagnostic criteria. The researcher found this discrepancy in terms of the role concerning. Again, the experience of the researcher is that the public sector and government bodies are more in favour of the statement that all social workers are trained to intervene. The workload in the public sector requires as many social workers as possible to intervene; therefore, there is no room for a discrepancy in terms of the background and training of social workers. However, the private sector focusses more on the level of care, and therefore rather supports a more specialized field of social work to provide a service in mental health.

Diagram 2:   Mental health approach
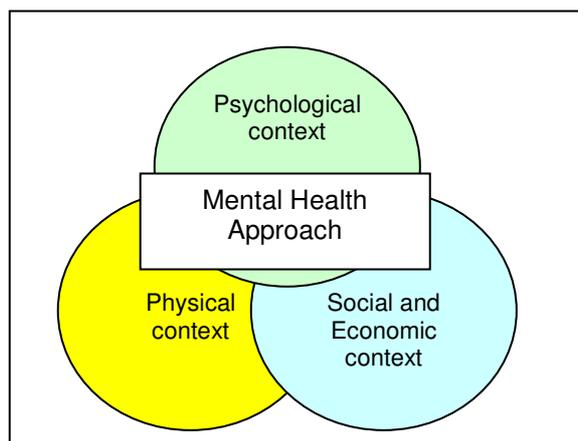
As visualized in Diagram 2, Baumann (1998:5); Borrell-Carrió et al. (2004:577), Sands (1991:53) and The *South African Mental Health Care Act* (17 of 2002) suggest a comprehensive primary health care approach to the delivery of health care services that consists of three cycles that will encompass the presenting symptoms of an individual.

Fisher, Newton and Sainsbury (1984:4) explored the 'social and economic context' twenty-eight years ago in their own enquiries into the role of social work in mental health and based their definition on two concepts: 'mental state' and 'social functioning'. They looked at cases where the impairment of social functioning (due to the social and economic context) could not be

wholly attributed to circumstances other than impaired mental state or health. Karpetis (2010:157) agrees and states that clinical social workers particularly assess the bio-psychosocial dimensions of mental health disorders affecting the client and his/her social network. The researcher agrees with Karpetis (2010:157) who is also of opinion that all aspects of social functioning and 'mental state' are contextual, and depend on a wide range of factors such as age, gender, intelligence, and sub-cultural value system.

Impairment with regard to 'mental state' includes the following:
- Impaired perception of reality includes significant distortions of reality or persistent misinterpretations, feelings of persecution, fears and hallucinations.
- Inappropriate feelings include depression, anxiety, apathy, aggressiveness and euphoria, which are inappropriate due to their depth, duration and setting.

Impairment with regard to social functioning includes the following:
- Economic impairment includes difficulties in maintaining paid employment, housework and childcare; impaired capacity to carry out a social role consistently or at a previous level of responsibility or efficiency.
- Interpersonal impairment includes persistent difficulties in:
  o Immediate family relationships such as spouse, children and other co-resident relatives
  o Wider social relationships such as other relatives, neighbours, friends and workmates
- Impairment in personal care includes self-neglectful and self-destructive behaviour.

Regardless of the variety of opinions, the researcher acknowledges the reality that social workers are working in mental health daily, irrespective of whether they are adequately trained or not. It is therefore important to understand the

role of all the mental health team members, in order to position the social worker within this team.

2.3 THE MENTAL HEALTH TEAM

2.3.1 Role of the mental health team

Teamwork has always been an essential element of good practice in mental health, which meets the needs of the ill person (Tilbury, 2002:60; Wilson et al., 2008:586). No one profession has the expertise or the authority to undertake everything. Teamwork is not always easy; different organizational structures and finance, varying degrees of operational autonomy, different approaches and priorities all play a role.

Mental and behavioural health problems can be viewed as an overlapping cluster of problems (Wilson et al., 2008:576). In the South African context, daily interactions take place between health related problems (e.g., heart diseases, depression and stress related conditions), social problems (e.g., child abuse, substance abuse and violence) and socio-economic problems (e.g. high unemployment, limited education and poverty). The *South African Mental Health Care Act* (17 of 2002 section 1:xvii) supports this explanation and defines mental health status as the level of mental well-being of an individual as affected by physical, social and psychological factors that may result in a psychiatric diagnosis. It is therefore acceptable that the mental health team will address all mental health problems in terms of psychological context, physical context and social/economic context, as seen in Diagram 2.

Borrell-Carrió, Suchman and Epstein (2004:577); Gunn and Blount (2009:236) and Wilson et al. (2008:576) are all of the opinion that mental health care forms part of overall health care, and therefore the physical context is as important as the psychological and social/economical context. The researcher agrees and emphasizes that the social worker is the specialist with regard to the social context within the mental health team and therefore will be able to

add valuable information to the social and economical contextual concerns and problems.

The way in which a patient becomes known to, or is referred to the mental health team, influences the role of the various team members. People with social problems often present in psychiatry for one of the following three reasons (Cockerham, 1996:1; Tilbury 2002:18). First, under pressure, they had made a suicidal gesture, or had threatened one, and were referred to psychiatrists because they were suffering from depression. They could just as well have expressed their distress by getting drunk, hitting someone, going shoplifting or turning up at casualty with some form of pain. These alternative expressions of distress would have landed them in different areas with different mental health team members and outcomes. The researcher regards this as an example of the symptoms rather than the problems determining which team member would be primarily involved, what would be deemed a mental health matter and a psychiatrist's concern.

Tilbury (2002:18) refers to a second group of people who had complained to their social worker or general practitioner (GP) that they were physically not feeling well because of their problematic circumstances that caused them not to feel well or in despair. Social workers and general practitioners may then make a referral when they are of the opinion that they cannot address the presented problems and seek the help of an alternative team member such as a psychiatrist.

The third type of referral, according to Tilbury (2002:18-19), is usually made due to the professionals' sheer frustration or irritation. The individual with the problem returned repeatedly and nothing tried by way of problem solving was successful. With all potential referral resources exhausted, the professional then requests a psychiatric report. It is clear that the referrers within the mental health team and health profession often have different reasons for referrals to team members in the field of mental health.

Simpson et al. (2005: 89) note that referral rates from general practitioners to psychiatrists remain low, due to the lack of psychiatric consultants. The researcher is of the opinion that this may be one of the reasons why mental health patients remain in one professional's care, and never receive treatment from a mental health team.

Le Page (2010) lists the following professionals as the mental health team:

- Initially the family doctor, but are then referred
- Psychiatrist
- Psychiatric nurse
- Social worker
- Clinical psychologist
- Occupational therapist
- Pharmacist
- Administration staff

The Community Care United Kingdom (2009) agree with the above and note that the training, ways of intervention and culture of multi-professional team members such as social workers, nurses, psychiatrists, and teachers will differ. The sectors of social care, health and education had major changes, restructuring and reorganization. The different roles, boundaries and ways of intervention will influence the working relationships of professionals. It is important that team members clearly know their own role and the roles of other team members (Fisher et al., 1984:45; Tilbury, 2002:19; Van Wyk, 2007).

Based on the researcher's experience, she concludes in agreement with Van Wyk (2007) that the psychiatrist usually leads, while each team member has a specific area of treatment. The ideal mental health team is a team that is actively involved with the patient/client and his or her family. Kerr et al. (2007:64) state that the mental health team delivers different kinds of services in different settings such as assessment, treatment and management of mental health patients. However, they also state that there has been very little

research on the quality or overall functioning of the various therapies provided by mental health teams.

2.3.2 Mental health team members

The various mental health team members are discussed below:

2.3.2.1 The psychiatrist

In the United Kingdom, the psychiatrist, seen as the professional with a high formal training status and effective control over the major resource, will make a recommendation, while the social worker decides whether to accept or reject the recommendation (Fisher et al., 1984:45). The researcher agrees with Van Wyk (2007) that in South Africa, the psychiatrist is the leader of the mental health team. However, the researcher also witnessed that in the public sector, the psychiatrist are appointed as the head, while in the private sector, the psychiatrist is rather seen as just part of the team, and has no official leading role.

Fifty percent (50%) of the social workers in in the study of Fisher et al. (1984:45) considered psychiatrists as professionals that offered only medication and containment, but almost as many referred to them in terms that are more positive, such as as having therapeutic skills, being good at their work and understanding towards their patients.

Le Page (2010) and Tilbury (2002:19-20) agree that there are instances where it is vital to bring in a psychiatric assessment, such as:

- To establish whether or not there is an organic basis for the disturbances in behaviour;
- There may be a case for the selective, short-term use of psychotropic drugs, to help bring acute symptoms under control, and enable some restoration of social functioning; and

- Medical help is needed where physical factors become involved, for example, patients with attempted suicide or other life-threatening conditions such as anorexia.

Le Page (2010) and Wilson et al. (2008:588) emphasize that the psychiatrist should determine whether the person being assessed is indeed suffering from a recognised and treatable mental disorder. The researcher summarizes the role of psychiatrists similar to Dinitto and McNeece (1990:14) who state that the psychiatrists prescribe a treatment (which could include medication, rest, counselling) for people with disorders and undesirable functioning of the personality. The researcher strongly agrees with the statements above but also found that psychiatrists, with psychotherapy training, often become therapeutically involved with the patients.

2.3.2.2   The general practitioner

Gunn and Blount (2009:237) mention in their research that other professionals referred to general practitioners' general lack of knowledge about mental health problems, and a few also suggested that general practitioners lack knowledge about the provisions of the Mental Health Act, sometimes to the extent of not fully recognizing their own role in the process of admission. About a third of their respondents made the point that a minority of general practitioners are very competent in mental health problems; they are knowledgeable, interested and prepared to take time to find out what is going on rather than immediately reaching for the prescription pad. Gunn and Blount (2009:236) and Wilson et al. (2008:568) note that in the United Kingdom, primary care providers such as general practitioners are now trained to become 'primary mental health care workers'. The researcher found that in South Africa the general practitioner often continues long term medical treatment with their private mental health patients, due to the good patient-doctor relationship and to maintain a patient base, although some general practitioners will assess a patient and refers to a more specialized professional (Le Page, 2010) when needed.

2.3.2.3   The occupational therapist

Having an occupational therapist in a mental health team is not always possible, but is ideally a valuable inclusion in the team (Le Page, 2010). The occupational therapist assists the mental health care user to first enable and secondly maintain their work abilities in order to return to their original employment. Occupational therapy is an important component in the Mental Health care within South Africa, since the occupational therapist is accepted as the team member who conducts the majority of mental health group work, not only in the private sector *HASA* [sa] but also in the public sector (Petersen, 2009).

The Life Path Health Group (2009) states that the occupational therapists conduct assessments to evaluate the symptoms and level of functioning of all mental health patients. They provide life skills training in group therapy, focusing on stress management, self-image and personality development, communication and interpersonal relationships, relaxation, day programme planning and a healthy lifestyle, and coping with negative emotions. The researcher experienced that occupational therapists add essential value to the treatment of mental health patients.

2.3.2.4   The psychiatric nurse

In the study conducted by Fisher et al. (1984:45), nurses are seen as providing valuable after-care services, having a partly monitoring and supportive role, and bringing some paramedical skills to the job - a sort of psychiatric 'barefoot doctor' service. Le Page (2010) and Petersen (2009) state that the psychiatric nurse tends to have the most frequent interaction with the patients and therefore are responsible to facilitate the treatment or care plan, and to monitor the levels of progress.

Life Path Health (2009) agrees that the monitoring and supportive role takes place 24 hours per day. The psychiatric nurse's role is not only to address physical concerns, but also to monitor patients and support them during the

entire treatment process. Nursing staff is also responsible for the distribution and monitoring of all prescribed medication while a patient is in the hospital. Petersen (2009) and Wilson et al. (2008:586) refer to psychiatric nurses as trained specialists in not only paramedical identity but specialists with particular mental health training that assists them to define their contributions. The researcher found that psychiatric nurses' input and observation could dictate treatment that is more effective and ensure correct care while providing treatment.

2.3.2.5   The psychologist

Social workers and psychologists, especially clinical psychologists, often work together as team members and there is a great deal of overlap in what they do (Dinitto & McNeece, 1990:14; Wilson et al., 2008:586). Both are interested in the behaviour of people and in their patterns of interaction. Both deal with the thinking processes of people. The psychologist, however, is interested primarily in understanding individual behaviour. While the psychologist focuses on individual behaviour, the social worker is interested in the social functioning of the individual. Le Page (2010) states the the clinical psychologist will provide therapy such as Cognitive Analytical Therapy (CAT), Cognitive Behavioural Therapy (CBT), Dialectical Behavioural Therapy (DBT), Interpersonal Psychotherapy (IPT) or Family Therapy.

A clinical psychologist is usually trained in formal, systematic and quantitative methods of assessment, and is skilled in providing Cognitive Behavioural Therapy treatment programmes (Wilson et al., 2008:586). The researcher agrees that the psychologist, especially the clinical psychologist, may intervene with individuals on an intensive basis in an attempt to change their behaviour, but the social worker is just as often interested in changing the individual's environment as in changing the individual's behaviour. Social workers therefore focus more on the social role of the client and on the utilization of community resources in order to meet a client's needs. Gunn and Blount (2009:236) express surprise to find that less than 33% of their patients diagnosed with a mental health disorder, has never received a consultation by

a psychologist or any other mental health professional. Petersen (2009) noted that she has seen in the South African private sector, that more and more non-clinical trained psychologists become part of the mental health team, due to the high population need for psychologist, and limited trained clinical psychologists.

2.3.2.6   The social worker

Social workers are often part of a mental health multidisciplinary system of care, working alongside colleagues who seem to have a much stronger knowledge base of mental health (Wilson et al., 2008:586). Le Page (2010) explains that social workers could even take on a similar role to that of a psychiatric nurse in terms of assisting the patient to understand the additional services or benefits that are available to support him/her. Munson (2002:8) and Rieman (1992:15) are of the opinion that there is a rapid growth of social work practice, and more specifically medical social work, stimulated by the need for interdisciplinary collaboration in multi-disciplinary settings and for teaching allied disciplines.

Social workers often do not involve other professionals but rather experience that other professionals involve them (Fisher et al., 1984:46). They admit that they only involve psychiatrists if there is a marked deterioration in the mental health of a client; but most of these social workers stressed that a referral is usually the last resort when the social work intervention proved ineffective or when they felt they lacked understanding of the nature of the problem.

Dinitto and McNeece (1990:14) emphasise the same experience and state that social workers will rather focus on coping tools for the clients' situations, than on the presence of mental health disorders. Wilson et al. (2008:589) state that social workers need to have a good working knowledge of psychiatric classifications of mental distress, but also need to retain their distinctive perspective on mental health work, which is about the total system of care, and how to work effectively with this.

Starnino (2009:836) and Wakefield, Kirk, Pottick, Hsieh and Tian (2006:213) observe that many social workers address poverty, administration, social policy, and other non-mental health concerns and are not clinically trained to use the DSM system. Non-clinical social workers and mental health professionals have vast differences regarding knowledge about mental disorders and their treatment. The researcher agrees with these statements, and understands that social workers often find it hard to sustain their professional identity in mental health, since they tend to see other professions as having more expertise.

Clinical training and experience however increase the ability to distinguish disorder from non-disorder (Wakefield et al., 2006:215). Starnino (2009:853-854) summarizes these views by stating that social workers have not only played a significant role in providing care for mentally ill patients, but fulfil a variety of roles such as:

- case manager
- therapist
- crisis counsellor
- program evaluator
- administrator
- policy analyst

Fisher et al. (1984:5), Sands (1991:53) and Straining (2009:836) state that the social worker's role in mental health is to assess the client's impairment in his or her social environment bearing in mind the individual's previous mental state and social functioning. Baumann (1998:31) supports this statement stating that the majority of people who experience psychological or social stresses do not suffer from psychiatric illness. Only a proportion of people may become ill because of extreme stress, but the majority cope due to a number of protecting biological, psychological and social factors.

The researcher summarizes the role of social work in mental health in Table 3 according to Dinitto and McNeece (1990:6); Sands (1991:17); Starnino

(2009:836) and the *University of South Africa* (2008); as a professional activity of helping individuals, groups or communities to enhance or restore their capacity for social functioning and creating societal conditions favourable to this goal. Starnino (2009:820) is of the opinion that social workers are the largest group of practitioners in the mental health field. Social work practice consists of the professional application of social work values, principles, and techniques to one or more of the following ends:

Table 3:   The role of social work in mental health

Social Work Role in Mental Health
1. Helping people to obtain tangible services
2. Counselling and psychotherapy with individuals, families, and groups
3. Helping communities or groups provide social and health services
4. Participating in relevant legislative processes
5. Maintaining, restoring and improving psychosocial functioning (creative activities, problem-solving skills, initiative, relationships, vocational activities, recreational activities, social activities and self-sufficiency skills).
6. Helping people enhance and more effectively utilize their own problem-solving and coping capacities
7. Facilitating interaction, and modifying and strengthening relationships between people within the resource system
8. Facilitating interaction, and modifying and building new relationships between people and society's resource systems
9. Establishing initial linkages between people and resource systems

Although various resources clearly indicate the presence and need for the role of social work in mental health, the researcher found that there are currently important debates and controversial statements with regard to the role of social work in mental health in South Africa.

Concerning the question regarding the role of social work in mental health, the researcher concludes that the social worker has a definite role to play in mental health. It would therefore be applicable that a training programme for social workers in mental health could be of value. The role of a social worker varies slightly according to the different mental health settings. The researcher

is of the opinion that it was important to identify and discuss the role of each mental health team member, since that would also clarify the role of social work.

2.3.2.7   Conclusions on the mental health team

Although not a recent reference, the researcher acknowledges Fisher et al. (1984:61) due to valuable information. In the mental health team, many general practitioners and psychiatrists share uncertainty about the role of social work, thus undermining the basis for co-operation that good liaison and joint rationale might provide. Neither general practitioners nor psychiatrists were generally prepared to ascribe to social workers a supportive role in medical intervention, in which they could act to promote the effectiveness of measures taken because of a primarily medical assessment. Both general practitioners and psychiatrists agree on the need for better-trained social workers, who would be more capable in skilled assessment and intervention, and whose role would expand as social aspects of mental health problems received wider recognition (Wilson et al., 2008:589).

According to the *South African Depression and Anxiety Group* (2009), South Africa has approximately 320 psychiatrists, giving a general ratio of about 150 000 people per psychiatrist. An estimated seven million people of the South African population belong to private health care with a remaining 41 million people in state health, while 200 of the 320 psychiatrists in South Africa work in the private sector (*Anxiety Group*, 2009; Bateman, 2010:352 and South African Depression). Gunn and Blount (2009: 236) and Baumann (1998:33) agree that about one third of patients attending a health care facility will require some form of psychiatric or psychological treatment. Given the ratios described above, the psychiatrist alone cannot provide such treatment. For this reason, the entire mental health team should possess basic psychiatric knowledge and should be able to apply this knowledge to local situations.

The researcher concurs with the information regarding the mental health team, and believes that any training for social workers in mental health related

issues would be valuable, due to the shortage of other mental health professionals, such as psychiatrists. The researcher deems it necessary to explore the qualifications of a generic trained social worker and a clinical social worker regarding their skills and training field.

2.4 SOCIAL WORK QUALIFICATIONS IN MENTAL HEALTH

The social work qualification in South Africa is an internationally recognized professional degree with an internationally accepted definition by the International Federation for Social Workers and the International Association of Schools of Social Work (*South African Council for Social Service Professions*, 2008a). Countries across the world recognize social work as an essential profession, and offer learning programmes at undergraduate and postgraduate levels, including specialized fields of practice (Addinall, 2011).

2.4.1   Graduate social work qualification

A South African social work professional refers to an individual with a four-year graduate qualification in social work. The social worker will then be a full professional in the field of social work (*South African Council for Social Service Professions*, 2008a).

The *SACSSP* (2008a) provides the following internationally accepted definition for the core purposes of a trained social worker:

> The social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilising theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

This definition provides clarity that social workers are trained in methods and skills to utilize theories of human behaviour and social systems to conduct social interventions. However, the question remains as to whether social

workers receive any specific training in mental health. Stromwall and Hurdle (2003:211) raise their concern by stating that many social workers remain unfamiliar of the perspectives and language used in mental health, and they suggest that the social work education programmes include content that is more specific.

Van Breda (2008), professor at the Department of Social Work, University of Johannesburg, states that their social work students receive one lecture in their first year on mental health as a field of social work practice. However, the students receive no training in mental health diagnosis or the use of any classification system. Van Breda (2008) presumes that the students learn about psychopathology in psychology, for those who enrol for psychology as a third year subject.

Addinall (2011), lecturer at the Department of Social Development, University of Cape Town, states that the department teaches mental health to their undergraduate students pertaining to the impact of mental health on the micro, mezzo and macro levels of society and the Mental Health Care Act. Addinall (2011) is of the opinion that mental health disorders and diagnosis are deemed to fit within the scope of practice of Clinical Social Work. Their social work students are introduced to diagnostic classification systems such as the DSM and ICD-10 with regard to the clinical role and organising, but not to the utilization or application thereof.

Addinall (2011) states that training in mental health is an international recognised field of speciality that requires specialised training. He further notes that there is definitely a need that social work programmes on undergraduate level should include:
- systemic perspective of the field of mental health,
- the impact of mental health on society from the following levels:
    - Individual
    - Family
    - Community

- o Societal level
- Legislation and policy governing mental health
- Recognising mental illnesses
- Knowledge of resources to refer to when needed

Addinall (2011) suggests that training on a more advanced level will have to focus on knowledge and skills to diagnose and treat mental illness, which he regards as being beyond the scope of practice of graduated social workers. Motloung (2011), lecturer at the University of Kwazulu Natal states that their department trains their undergraduate students in mental health care, mental health diagnosis and the DSM-IV utilization. However, they do not offer any training on postgraduate level in the field of mental health.

Carbonatto (2007), senior lecturer at the Department of Social Work and Criminology, University of Pretoria, mentions that undergraduate students in social work receive an introductory module in health and some mental health aspects, including psychiatric conditions and information on the DSM. Social workers, who continue with a postgraduate qualification in Play Therapy or Employee Assistance Programmes (EAP) in the department, will spend only one day on DSM training.

The four-year degree does not prepare social workers to be mental health workers, but the academic institutions merely introduce the concept of mental health to the students. The researcher is concerned that social workers without specific training in the DSM system will have limited knowledge, although they are expected to know of and utilize this system.

Reyneke (2008), Departmental Chairperson for the Social Work Department at the University of the Free State, says that the department invites a guest speaker to provide an introduction on the complexity of psychiatry and highlights the Mental Health Care Act. He is of the opinion that psychiatry is a much-specialized field, and suggests induction training in the DSM system for those who enter the field, since their department does not provide any training

in diagnostic systems. The undergraduate social work training at the University of the Free State refers to the DSM system in a module on loss and trauma. However, they plan to add Obsessive Compulsive Disorder and Attention-Deficit and Disruptive Behaviour Disorders as documented in the DSM-IV-TR to the curriculum content. The researcher regards this as positive since these two disorders are client behaviours known to every social worker.

In conclusion, the researcher agrees with Rwomie (2011) who has found that social workers are well equipped with knowledge and understanding of human behaviour and social systems. They learn the skills to intervene where people interact with their environments in order to promote social well-being. Social workers can assist and empower individuals, families, groups, organizations and communities to enhance their social functioning and their problem-solving capacities. Social workers are able to promote, restore, maintain and enhance the functioning of individuals, families, groups and communities by enabling them to accomplish tasks, prevent and alleviate distress and use resources effectively.

From the information above, it seems that social workers will only receive specialised training in mental health, if they enrol for a post-graduate qualification. Social workers have the ability to address the needs of mental health patients, and could contribute to the treatment plan of any mental health team. The researcher is convinced that social workers should have more knowledge regarding mental health disorders, since that knowledge will empower them not to diagnose, but to assess more comprehensively and to make more appropriate referrals and recommendations.

2.4.2   Post-graduate social work qualifications

Following a first degree, the social worker will have the choice to continue with studies in order to obtain a Magister Artium (MA) Degree in Social Work. In South Africa, the qualification is offered as a Research Masters Degree or as a Coursework Masters Degree with various fields of specialization. It is generally a minimum two-year study programme. The coursework Masters

degree that specialises in mental health varies between universities and universities have their own curricula for a social work postgraduate qualification in mental health.

The *South African Council for Social Service Professions* (2008b) provides a document, *Masters Degree in Social Work*, with their views and interpretation of the social work qualifications. According to the document, the Masters qualification compares to similar international qualifications for Social Work, verified through the South African structures affiliated with the International Association of Schools of Social Work (IASSW). The IASSW formulated a draft document on Global Qualifying Standards for Social Work Education and Training and continues to promote global standards. The chairperson of the Global Qualifying Standards Committee is a South African citizen and has served on the SGB for Social Work since its inception (*South African Qualifications Authority*, 2008).

Table 4 indicates the variety of Masters Degrees for social work in the field of mental health at the following ten traditional universities in South Africa. The table includes a comparison *North-West University* (2010); University of Kwa-Zulu Natal (Motloung, 2011); *University of Cape Town* (2010); *University of Johannesburg* (2009); *University of Limpopo* (2011); *University of Pretoria* (2009); *University of Stellenbosch* (2009); *University of the Free State* (2009); *University of Western Cape* (2010) and *University of Witwatersrand* (2009).

Table 4:   Social Work Masters degrees at South African Universities

Academic Institution	Social Work Masters degrees
North-West University	• Master of Social Work – M(SW)

University of Cape Town	• Coursework Masters (MSocSc)
	
	    o **Clinical Practice in Social Work (MsocSc)**
	    o Probation and Correctional Practice
	    o Social Development
	    o Social Policy and Management

	• Research Masters
	   o Social Work
	   o Social Planning and Administration

University of Johannesburg	▪ Masters (Soc Sc) Community Development ▪ **Masters (Soc Sc) (Clinical)** ▪ Research MA in Social Work
University of KwaZulu-Natal	• Masters in Welfare Policy and Development • Research Masters • Masters in Child Care and Protection • **Masters in Health Promotion**
University of Limpopo	• No post graduate programmes
University of Stellenbosch	▪ Research Masters in Social Work ▪ Welfare Programme Management

University of the Free State	▪ Research Masters in Social Work
	▪ Coursework Masters:
	   o **Clinical MA**
	   o Case Work MA
	   o Research methodology and report

University of Pretoria	▪ Coursework Masters Programme in Social Work
	   o MSW Social Development & Policy
	   o MSW Play Therapy
	   o MSW/MSocSci Employee Assistance Programmes
	   o **MSW Social Health Care**
	▪ Research-based MA

University of Western Cape	• Coursework Masters • Masters in Child and Family studies • Masters in Social Work by thesis
University of Witwatersrand	• Masters in Social Development by coursework • Research Masters in Social Work • Occupational Social Work

The variety of Masters Degrees in Social Work in South Africa is evident from the table above. Various courses overlap, but there is no national standardized social work training field in South Africa for mental health as such.

The *University of Stellenbosch* (2009) states that the Welfare Programme Management course includes perspectives, theories and models for social work intervention, but the department has no alternative course specifically in mental health. Green (2008), a professor at the Department of Social Work, University of Stellenbosch states that training for social workers in the DSM-IV is the responsibility of the Psychology department, presumably if the student is interested in psychology and carries it as an elective to the third year during the pre-graduate training. However, the researcher questions the relevance, since a mental health approach consists of a psychological, physical and social economic context. The psychology department will focus on the psychological context within mental health, but the social work department needs to address the social economic context pertaining to a mental health patient and this can only be done with adequate knowledge of mental health.

Addinall (2011) from the Department of Social Development, University of Cape Town, notes that the postgraduate qualification in Clinical Social Work is a two-year Masters degree and involves in-depth specialised knowledge and skills training in psychiatric illness from appropriate clinical theoretical models. The training focuses on:

> … child psychiatric disorders, adolescent psychiatric disorders, adult psychiatric disorders (all inclusive of the DSM-IVTR diagnostic criteria), to clinical assessment and diagnosis of psychiatric disorders to advanced psychotherapeutic interventions with children, adolescents and adults impacted by psychiatric illness including individual psychotherapy, couple therapy, family therapy and psychotherapeutic group therapy.

Reyneke (2008) mentions that the Department of Social Work at the University of the Free State informs their Masters Degree students of mental health diagnostic systems, more specifically the DSM-IV-TR, since various

disorders such as posttraumatic stress disorders and anxiety disorders are part of their "loss and trauma" module. However, he states that they do not teach students to diagnose, but rather to understand and know the diagnostic language. According to Van Breda (2008), the clinical social work module at the University of Johannesburg focuses on psychopathology, psychiatric assessment, mental health care, mental health diagnosis and the DSM.

Reyneke (2008) references Dr Ferreira, also a lecturer at the University of the Free State, who informed him that the DSM system has a definite place in the training of social workers, but without the necessary cultural sensitivity. Van Breda (2008) supports this statement as well but notes that he is more concerned about the social workers' ability to write psychosocial reports than their ability to diagnose. He is of the opinion that 'diagnosis' or the competent use of DSM is a post-graduate competency.

Based on the above, it is clear that only a limited number of academic institutions offer a specialized Masters degree in mental health work, including clinical social work. The majority of social workers will have to use their skills as acquired in their undergraduate training when they deal with mental health care users.

In the next section, the researcher will discuss the definition and role of clinical social work compared briefly with other social work masters qualifications, due to the controversial issues raised by various stakeholders in the South African health sector.

2.4.3   Mental Health Social Work Qualification

Dinitto and McNeece (1990:39) ask the following question: "Do social workers know enough about professional competencies at different levels of practice to make adequate distinctions, or would broader categories better serve their purpose?" The United States developed and implemented the following four professional levels of qualifications in social work in 1973, which they are still using:

- Certified social work: requiring a professional credential or similar recognition by a state certification or licensure board

- Social worker: this requires a four-year baccalaureate degree from an accredited social work programme

- Graduate social work: requiring a masters degree from an accredited social work programme

- Social work fellow: requiring a doctorate or substantial experience beyond the national minimum standards

Organizations can assign workloads to social workers according to their levels of qualifications and expertise. However, Simpson et al. (2007:4) agree with Dinitto and McNeece (1990:39) who state that the work of social workers with different qualifications overlaps considerably. For example, social workers with both Bachelor and Masters Qualifications provide counselling, and their ability to counsel effectively may depend on their personal characteristics, such as the empathy they convey to clients, in addition to their professional training and experience. Dinitto and McNeece (1990:39) have found that the inability to differentiate the social work tasks and responsibilities according to qualifications as described above causes confusion amongst social workers. The researcher acknowledges this statement, and found in her social work experience that a social work Masters Degree qualification has enabled her to be appointed on a higher salary level based on her postgraduate qualification, but the qualification had no impact on the tasks or duties assigned to the social worker.

Social workers are Mental Health Practitioners according to the *South African Mental Health Care Act* (2002 section 1:xvii). However, Duncan (2008) argues on behalf of the Clinical Social Work Interest Group that not all social work qualifications equip social workers to be skilful enough in the field of mental health, and that only Clinical Social Workers are trained to operate in mental health institutions. Munson (2002:8) states that the term "Clinical social work" is a relatively new term within the South African context, but the practice of clinical work has been around for decades. The researcher agrees with this

author and found that professionals in the mental health sector and the academic sector did not have a clear scope of practice for social workers known as 'Clinical Social Workers'.

Cooper and Lesser (2002:1) and Simpson et al. (2007:4) both refer to a clinical social worker as a social worker that aims to enhance and maintain the psychosocial functioning of individuals, families, and small groups. A clinical social worker applies social work theory and methods to treat and prevent psychosocial dysfunction, disability, or impairment that include emotional and mental disorders.

Simpson et al. (2007:4) agree with Dziegielewski et al. (2002:37–38) who declare that knowledge of diagnostic categories and criteria can assist the clinical social worker to enhance the individual's overall level of functioning. Social workers often have regular and subsequent contacts with their clients and therefore can assist the multi-professional team to re-examine and/or re-formulate previous diagnoses. Treating an individual is a team effort and social workers are qualified and trained to be aware of the importance of building and maintaining a therapeutic rapport with the individual. The researcher believes that if the social work qualification includes training on the mental health therapeutic language regarding diagnostic terminology, social workers could make an essential contribution to intervention effectiveness within the multi-professional team.

In the United States of America, the qualification as a 'licensed clinical social worker' implies a social worker legally accredited by a state government to practice clinical social work in that state. Qualifications for the licence vary from state to state, but typically include an accredited school of social work, several years of supervised professional experience and successful completion of a social work licensing exam (Gibelman, 1995: xxvi). Simpson et al. (2007:3) mention that in the United States, 41% of all outpatient mental health services delivered by clinical social workers.

The researcher experiences that in South African social work practice, social workers regard themselves as an accredited qualified "clinical social worker" when the social worker has completed a Clinical Masters Degree in Social Work. However, Duncan (2008) states that there is no accredited Clinical Social Work category in South Africa, although the Clinical Social Work Interest Group is in discussion with the national regulators requesting an addendum to the act to make such an accreditation available. The researcher is concerned about isolating 'clinical social work' since Table 4 indicated that South Africa does not have a nationally standardised clinical social work qualification. The researcher is of the opinion that such an accredited qualification in mental health should be based on similar criteria as in the USA, as noted by Gibelman (1995: xxvi) above.

It is clear to the researcher that there is tension in the practice of social work and Cooper and Lesser (2002:8) emphasize that this tension is also present in the USA. First, there has been on-going disagreement over the term clinical social work, since this tension reflects the conflicting views within the profession about its mission. Who has the right to entitle himself or herself as a 'clinical social worker'? Van Breda (2008) states that even though he is trained as a Clinical Social Worker, and teaches a module in 'Clinical Practice in Diverse Environments', he is of the opinion that there are large gaps in many programmes regarding 'clinical'. His definition for clinical social work is a combination of work with mental health problems or psychopathology and secondly, intensive or advanced therapeutic interventions at micro and meso levels. He is of the opinion that there is a tendency to equate 'clinical' with 'therapy', and although this is central, one cannot be 'clinical' without a thorough grounding in psychopathology and psychiatry. The researcher agrees, and suggests that the definition and training of 'clinical' social work should rather primarily focus on in-depth training in psychiatry, psychopathology and psychotherapy for the psychiatric patient. Currently, this seems to be a field of study not offered by the majority of universities, and therefore a licensing system, similar to that of the USA would be a more sustainable way of accrediting 'clinical social workers'.

A second tension mentioned by Cooper and Lesser (2002:9) and Duncan (2008) and is whether social work practitioners should be using the DSM system or diagnosing clients at all. Some social workers oppose labelling clients according to symptoms. However, in some cases, a diagnosis can actually empower clients who struggle with emotional problems, and present a name, and hopefully, a treatment, to alleviate their distress. The researcher agrees with Cooper and Lesser (2002:9) who state that the insensitive and misinformed use of diagnostic classifications is harmful to clients. Clients should never be referred to as 'borderlines' or 'schizophrenics'. For example, Cooper and Lesser (2002:9) note that social workers should rather maintain a powerful voice in ensuring that the DSM (or any other diagnostic classification) continues to improve. This would include cultural sensitivity since culture-bound syndromes are not incorporated into the multi-axial structure of the DSM-IV.

The researcher is of the opinion that the Clinical Social Work Interest Group primarily has concerns pertaining to social workers who diagnose mental health patients without adequate training. The researcher emphasizes that the training for social workers, as referred to in this study, is not intended to train social workers to diagnose, but rather to train social workers in the use of a diagnostic system in order to understand the mental health language and the disorders that their clientele could present with. Simpson et al. (2007:12) conclude:

> Moving forward into the twenty-first century with its promises of accelerated global and technological changes, the (social work) profession must remain vigilant about the fact that education is not just about the present. It is also fundamentally about the future.

However, the researcher believes that social workers (generically or clinically trained) have a huge challenge ahead, to improve and demand the valuable role they could play in mental health. The researcher is of the opinion that the methods and approaches used in social work mental health will assist in finding the scope of practice for social work in mental health.

2.5 SOCIAL WORK METHODS AND APPROACHES IN MENTAL HEALTH

It is important to clarify the meaning of mental health in order to understand the social work methods used in mental health. Dinitto and McNeece (1990:107) and Smit (2012) explain that one possible reason why so many social workers practise in the mental health field is that such a large number of people experience mental health problems.

Simpson et al. (2007:7) note that social work is about understanding the clients' subjective realities and responding to their difficulties, pain, strengths and humanity. However, the definitions of 'mental disorders', 'mental illness' and 'mental health' vary according to cultural norms and values. These definitions are discussed in the next chapter. Sands (1991:16) defines mental health in the following way:

> A state of psychosocial functioning that ranges from dysfunctional (mental illness) to functional to optimal. Optimal captures qualities of positive mental health as defined by the individuals own culture. Mental health is a phenomenon of the individual, family, group, community, culture, and nation. What affects one of these systems affects others. Physical, psychological, and social dimensions are connected.

Sands (1991:17) provides a mental health functioning continuum which indicates that an individual is more or less functional with respect to different activities. The researcher agrees that people may function at a relatively higher level in some areas (such as managing rent, use of transport), while functioning at a dysfunctional level in other areas (interpersonal relationships, employment). Simpson et al. (2007:4) and Sands (1991:17) agree that the goal of social work mental health intervention is to help the person to maintain, restore, or improve psychosocial functioning, such as the person's creative activities, problem-solving skills, initiative, relationships, vocational activities, recreational activities, social activities and self-sufficiency skills.

The researcher presumes that social work intervention within South Africa is generally regarded as a social work service to families and/or individuals, and

therefore has been termed 'social casework' from the early beginnings of professional social work. McKendrick (1993:47) embraced social casework as:

> A philosophy and value system centred on the worth and dignity of the individual. A willingness to provide a wide and comprehensive range of services, dealing with a broad continuum of human, personal and social functioning: a commitment to serving the most stigmatized groups in society, a recognition that without primary attention to and concern with individuals, the entire society suffers.

The University of South Africa refers to three primary methods of intervention in social work, namely intervention with individuals and families, group work and community work (University of South Africa, 2008). For the purpose of this study, the researcher will only focus on the first method of intervention, namely direct social work or intervention with individuals and families.

2.5.1 Direct social work as a method of intervention on micro level

Dinitto and McNeece (1990:73) remark that twenty years ago, casework in social work had two persistent themes, namely the need to individualize people and secondly the need to understand (diagnose) situations. The term social 'diagnosis' fits well into a medical framework for practice, since it was suggestive of the idea that cases (people) could be viewed as either sick or well. Literature that is more recent refers to casework in social work as 'direct work' (Coady & Lehmann, 2008:3; Simpson et al., 2007:3).

The researcher's experience is that casework or direct work may be regarded as a method of the social work profession, with its defining characteristic being the provision of individualized service. Coady and Lehmann (2008:3) describe 'direct social work practice' as clinical or micro social work, working with individuals, families or even groups. McKendrick (1993:48) confirms that social work professionals no longer regard themselves as dispensers of charity, but rather as 'social physicians' concerned with social maladjustment rather than with material need. Simpson et al. (2007:3) agree and note that in the United States 70% of social workers on Master's level and 40% of social workers on Doctoral level describe their primary function as direct services.

McKendrick (1993:46) argues that in South Africa, graduated social workers draw deliberately and specifically upon a wide knowledge and skill base to respond relevantly to a particular unique client situation. The intervention method could be through social group work, social casework, family therapy or community work, or any combination of these. Dinitto and McNeece (1990:107) are of the opinion that social workers in public mental health settings work primarily with those who have a serious mental illness (SMI). The population with SMI such as schizophrenia or bipolar illness have chronic or persistent conditions with no known cure.

The researcher observed that social workers often serve as broker between this population and mental health providers, and provide therapy for clients and their families. Dinitto and McNeece (1990:110) and Smit (2012) state that social workers work in many capacities with various approaches in the mental health field to ensure that clients receive the services they need.

2.5.2   Social work approaches in mental health

Brubeck (1999:126) clearly states that the concern regarding social workers who diagnose or assess, has a long history dating back to at least 1917. She is also of the opinion that social work individual assessments have traditionally focused on the individual's interaction with the environment as well as the individual's interaction with these systems. Dinitto and McNeece (1990:73-74), McKendrick (1993:47) and Simpson et al. (2007:7-11) state that social workers use many different approaches and direct work is based on many theoretical orientations. Coady and Lehmann (2008:5) state that generalist social workers could adopt the generalist-eclectic approaches when they practice direct social work.

Dinitto and McNeece (1990:75) and McKendrik (1993:53) agree that there is a definite thrust towards developing a generalist approach to social work practice. The goal of intervention with a generalist-eclectic approach is to bring about positive change in the client's functioning or in environmental

factors immediately impinging on the client's functioning (Coady & Lehmann, 2008:5). The roles of a social worker range from behaviour changer/clinician to consultant/educator to broker/advocate. The following approaches are provided by Coady and Lehmann (2008:5-8) and Simpson et al. (2007:5-7).

2.5.2.1   The psychosocial approach

The systems theory approach originated from the person-in-environment configuration, which developed into the psychosocial approach (Coady & Lehmann, 2008:5; Simpson et al., 2007:5). The person is seen in the context of his/her interactions or transactions with the external world such as family, work place or school system. Treatment must be individualized, recognizing systems within which the individual exists or which impinge on his/her existence. The intervention is either direct, or indirect or environmental treatment. The following table indicates what the treatment includes (Dinitto & McNeece, 1990:73-74; McKendrick, 1993:47; Simpson et al., 2007:5).

Table 5:   Psychosocial treatment

Direct Treatment	Indirect Treatment	Environmental Treatment
Sustaining procedures		
Procedures of direct influence		
Catharsis or ventilation		
Reflective discussion (of current situation, client responses to it and interaction)		
Reflective discussion (of dynamics of response patterns or tendencies)		
Reflective discussion (of genetic development of response patterns or tendencies)		
		Procedures involving provision of environmental services, i.e. financial assistance

The researcher often adopts this treatment approach in practice, since the individualized treatment puts the client at ease and ready for change.

2.5.2.2   The cognitive behavioural approach

The cognitive behavioural approach refers to behaviour modification that has techniques that have a wide range of applicability in terms of social work clients and problems (Dinitto & McNeece, 1990:74 McKendrick, 1993:51; Simpson et al., 2007:8). The cognitive behavioural approach aims to assist the client to understand the cognitive processes that guide the interpretation of incoming information, as well as the accompanying behaviour.

Dinitto and McNeece (1990:74), McKendrick (1993:50) and Simpson et al. (2007:8) define this approach as a process that is a forward moving course of transactions between active agents. The active agents are the social worker, the client and the people in the client's environment. Simpson et al. (2007:8) clearly state that this approach uses cognitive restructuring in order to have guided imagery, behaviour modification, self-regulation and problem solving. Coady and Lehmann (2008:6) refer to this approach as the problem-solving approach. However, Simpson et al. (2007:8) state that problem solving does not differentiate between psychological and environmental problems and procedures. The emphasis is rather on the person in need of help to become his or her own problem-solver.

The researcher found this approach as a process that involves identification of the problem by the person and exploration of his subjective experience of the problem and problematic areas. Part of this approach could also be to find alternative solutions by discussing and reaching conclusions, which will lead to action to test out the solution. The researcher found this approach to be very concrete with clear measurable changes in behaviour.

2.5.2.3   Family systems approach

The family systems approach refers to working with families as a system and is an integral part of the social work profession (Greene & Cohen, 2005:368; Simpson et al., 2007:8). The family systems approach accepts the family as a psychosocial unit where all members of a family can affect and influence one

another (Wilson et al., 2008:373). Family cohesion can change at any time; whatever occurs to one member could affect the entire family. Changes in one part of a family will bring about change in other subsystems. Simpson et al. (2007:8) agree that the family is a living, active system, embedded in the larger population, but with its own developmental line.

The researcher is of opinion that all these approaches add value and that social workers should use the approach most applicable to the context, the problematic situation and the approach that they feel comfortable using.

The researcher will discuss the rationale for utilising the DSM system in Chapter 3, refer to various important definitions, provide information on the history of the DSM system, explain the multi-axial systems and conclude the chapter with the limitation and advantages of the DSM system.

2.6 SUMMARY

From the available literature regarding the use of the DSM system in practice, it is obvious that more attention and investigation in this area is needed, since knowledge of the disorders, as defined in the DSM system, can benefit the social work profession. Social workers are expected to use the DSM system although many have no official training in this field. The researcher is concerned that social workers without specific training in the DSM system will have limited knowledge, although they are expected to know of and utilize this system.

Any social worker may come across mental health work emphasising the importance of including information about mental illness as an integral part of the basic training in social work. The researcher accepts that social work practice in mental health takes place in a number of different settings. Among these are mental health centres, outpatient clinics (general or psychiatric hospitals), partial hospitalization, day treatment programmes, emergency and crisis intervention services, inpatient hospital treatment, employee assistance programmes and private practice. Within all these programmes, alternative

services such as psychotherapy (individual, family and group), social skills development, and vocational rehabilitation should be offered.

Social work adopts a breadth of theoretical approaches and treatment modalities, a commitment to diversity and social justice, and a trend towards empirical evaluation of social work practice. Social work developed into profession of comprehensive processes of assessment, diagnosis and treatment within the social environment.

The role social workers could play in the field of mental health could increase more. The development of adequately operationalized and empirically tested contextual systems of assessment remains a principal challenge for contemporary social work. The value and benefit of intensive group training in the DSM system for social workers in South Africa needs to be assessed and researched since no data is available to verify this problematic area.

CHAPTER 3
THE DSM-IV SYSTEM

3.1 INTRODUCTION

The field of mental health intervention involves everything from divorce adjustment services to the treatment of depression and schizophrenia. Treatment of alcoholism and other forms of substance abuse also falls under the umbrella of mental health services. In the previous chapter, the researcher focused on the role, qualifications and methods used in social work pertaining to mental health.

Intervention with people is an integral part of social work, and therefore the possibility of working with a mental health patient is unavoidable. Clients might ask a very valid question, "How do you as professional know that I am depressed, addicted or bipolar?" Against what criteria does a mental health professional assess or screen a client?

The researcher found that the diagnostic criteria manual most widely used across the world is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), which provides diagnostic criteria for mental disorders, developed and published by the *American Psychiatric Association* (1994). Clinicians, researchers, psychiatric drug regulation agencies, health insurance companies, pharmaceutical companies and policy makers use the manual in varying degrees around the world. The increasing utilization of the DSM in the mental health field has created a professional boundary problem, especially for nonmedical practitioners, such as social workers (Brubeck, 1999:121).

The researcher aims to assess the need for a social work training programme in the DSM system. The previous chapter focused on the South African context of social work in mental health, and conceptualized the social worker's role, qualifications and training in mental health. However, the researcher deems it necessary to provide information on the DSM system, in order to

contextualise whether training in this system could benefit the social work profession. This chapter will discuss why the research study is focusing on the DSM system, the terminology in the DSM such as 'mental health', 'mental illness', 'mental disorder' and 'psychosis', the history as well as the multi-axial assessment of the DSM system, and will conclude with the limitations and advantages of the DSM system.

3.2 THE DSM SYSTEM AND THE ICD SYSTEM

The researcher had the choice to focus on either the DSM system or the ICD system. Torrey (2009) refers to the *International Statistical Classification of Diseases and Related Health Problems*, 10th edition, as ICD-10. ICD codes are alphanumeric designations given to every diagnosis, description of symptoms and cause of death attributed to human beings. The World Health Organisation (WHO) develops, monitors and copyrights these classifications.

The *Board of Health Care Funders* (2007) states:

> The Council for Medical Schemes and the National Department of Health support the implementation of ICD-10 in the public and private health sector. This is a diagnostic coding standard adopted by the National Department of Health in 1996 and is now the responsibility of the National Health Information System of South Africa (NHISSA). It is a diagnostic coding standard accepted by all the parties as the coding standard of choice for all diseases.

However, it seems that in mental health, service providers and administrators still prefer the use of the DSM system, especially in the South African context. Allers (2008) and Collin (2008), both experienced psychiatrists in private practice, state that the DSM system is far more comprehensive than the ICD-10 coding when dealing with mental disorders. Dittmer (2011), Kriel (2011) and Pridigeon (2011) confirm that all medical aids in South Africa request a DSM diagnosis from a psychiatrist before they will authorize mental health treatment and services rendered under mental health benefits.

Duncan (2008), a social worker with a clinical social work qualification in Cape Town, highlights the critical time in South Africa pertaining to the debate regarding "social workers' field of competence" in terms of diagnoses and ICD-10 coding. It is important to note that all practitioners in South Africa, including social workers, use ICD-10 codes when they process their medical aid claims for services rendered. However, the researcher first needs to clarify the practical utilization of the ICD-10 codes against the DSM when accessing mental health benefits in the South African private health funding system.

Dziegielewski et al. (2002:220) explain that the DSM is similar to the ICD since both have diagnostic codes, however clinical practices often use the ICD for billing purposes but refer to the DSM to clarify diagnostic criteria.

The South African National Task Team for the ICD-10 Implementation Review (*Council for Medical Schemes*, 2010:6) defines the ICD-10 as an International Classification of Disease, 10th edition. This is a standard diagnostic classification/coding adopted by the South African National Department of Health in 1996. The National Department of Health and the Council for Medical Schemes (*Council for Medical Schemes*, 2010:6) support the implementation of the ICD-10 in the public and private sector in South Africa. The National Task Team for the ICD-10 Implementation Review (*Council for Medical Schemes*, 2010:68) states that all health care providers, diagnosing and non-diagnosing, should by law provide a diagnosis code on all medical aid claims.

However, it is important to note that the ICD-10 is standard diagnostic coding for international diseases (*Council for Medical Schemes*, 2010:6) which means that it is a list of diseases, each one with a dedicated ICD-10 code. The DSM system is a diagnostic classification system, specifically for mental health disorders, which also has a list of mental health disorders with their own specific codes, but with clear, detailed classification criteria on each disorder. This is one of the main reasons why the South African Society of

Psychiatry (Allers, 2008) states that the DSM is the most comprehensive diagnostic and used criteria for psychiatry in South Africa.

The ICD-10 coding will therefore only provide a code for each mental health disorder, while the DSM system has a detailed classification guideline, using a multi-axial classification scheme consisting of five axes (Kaplan, Sadock & Grebb, 1994:280).

In support of the utilization of the DSM system, the researcher found that the DSM system is also the preferred clinical diagnostic criteria in the private mental health hospital industry in South Africa. The association for all private hospitals in South Africa, namely *Hospital Association of South Africa* (HASA) [sa] states that there are currently 247 private hospitals with 30 334 beds in South Africa. *HASA* [sa] further note that due to the increasing demand for private mental healthcare facilities, HASA initiated the Psychiatric Focus Forum (PFF) in 1977.

The researcher is actively involved with the PFF and agrees with *HASA* [sa] who note that the PFF is a dedicated forum that not only addresses but also improves the image and infrastructure of psychiatry in South Africa. The PFF represents most of the private psychiatric hospitals, or mental health facilities and substance abuse rehabilitation units in South Africa. The 22 PFF private psychiatric hospital members are: Bloemcare Care Centre, Claro Clinic, Claro Clinic Addiction Treatment Centre, Crescent Clinic in Johannesburg, Denmar Specialist Psychiatric Hospital, Elim Clinic, George Med-Clinic, Glynnview Clinic, Kenilworth Clinic, Life Entabeni Hospital, Life Huterscraig, Life St. Marks, Life Riverfield Lodge, Life Roseacres, Life Westville, Parkmed Neuro-clinic, Pines Clinic, Riverview Manor Specialist Clinic, Sereno Clinic, Stepping Stones, Tijger Clinic and Vista Clinic.

All the private psychiatric hospitals mentioned above have the same psychiatric admission and administration criteria, individualized for each of the 110 medical aids, as registered with the Council for Medical Schemes in 2009

(Clark, 2011). The Council for Medical Schemes and the Department of Health support the implementation of the ICD-10, and request such a code/s on all claims. Medical aids such as Discovery, Polmed, GEMS (Government Employees Medical Scheme) and Liberty only approve mental health admission with a comprehensive DSM-IV report for all psychiatric/mental health related services (Discovery Health, 2009; Government Employees Medical Scheme, 2010; Liberty Medical Scheme, 2010; Polmed, [sa]).

Although a psychiatrist must complete these psychiatric reports, Dittmer (2011), Kriel (2011) and Pridigeon (2011), all case managers for different private psychiatric hospitals state that the DSM system is far more the focus in the clinical approach, while the ICD-10 codes are rather an administrative tool for billing and statistical purposes. All other service providers will only receive reimbursement from the mental health benefits, if there is an authorized DSM report. Without a report, all the fees will be covered from the limited day-to-day benefits. Due to the practical importance of the DSM report and diagnosis, the mental health team in the South African context refer to patients and their prognosis (and progress) within the mental health team with reference to the DSM system.

The ICD includes a section classifying mental and behavioural disorders. Significant differences between the DSM and ICD systems include that unlike the DSM the ICD include personality disorders on the same axis as other mental disorders. The *World Health Organisation* (WHO) (2009) currently revises classifications in these sections for the development of the ICD-11, scheduled for 2015 with an "International Advisory Group" to guide the process.

In conclusion, to the motivation for the DSM utilization, the researcher emphasises that currently social workers in South Africa will have to use an ICD-10 code when they consult with a medical aid patient out of hospital, and want to claim funds for their services (*Council for Medical Schemes*, 2010:6). If these claims were accepted, it would be paid from the patient's day-to-day

benefits, and not from the dedicated mental health benefits, which is often the reason why social workers are not selected as service providers (Smit, 2012).

As the Operational Manager for four private psychiatric clinics, the researcher found that the DSM forms for psychiatric admission have to be completed if a mental health in-hospital admission is approved with the dedicated mental health funds. Only then will social work consultations in a hospital be considered for payment from the mental health benefits. Most of the time medical aids request a motivational letter from a psychiatrist to motivate the role of the social worker, since social workers are not recognised as mental health service providers within the psychiatric treatment plan as discussed in Chapter 2 point 2.2.1 (Discovery Health, 2009; Government Employees Medical Scheme, 2010; Liberty Medical Scheme, 2010; Polmed, [sa]).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is an important alternative to the mental disorders section of the ICD (Mezzich, 2002). It is the primary diagnostic system for psychiatric and psychological disorders in the United States and other countries, while it is used as an adjunct diagnostic system in many countries. Collin (2008) confirms this statement and is of the opinion that the DSM is the classification system most often used and referred to in South Africa regarding the diagnosis of mental disorders. Mezzich (2002) mentions that since the 1990s, the authors of the DSM, the American Psychiatric Association and the authors of the ICD, the WHO, have worked to bring the DSM and the relevant sections of ICD into concordance, but some differences remain.

The researcher is of the opinion that the arguments above would explain that it would be far more practical and appropriate to apply this research to the DSM system, and not the ICD-10 system. The DSM system is not only used worldwide, but also accepted as a more effective and comprehensive system, specifically with mental health disorders within the South African mental health field and funding system.

In order to understand the DSM system better, the researcher finds it necessary to discuss terminology used in the DSM system.

3.3 TERMINOLOGY IN THE DSM SYSTEM

The researcher agrees with Dinitto and McNeece (1990:107) who are of the opinion that it is important to acknowledge the individualism of each client. Definitions for 'mental disorder', 'mental illness' and 'mental health' vary according to cultural norms, values and research criteria, although the authors of the DSM-IV have tried to reduce definitional problems by specifying bio-psychosocial criteria for each mental disorder. The researcher will discuss all three mental states, namely mental health, mental illness and mental disorders as well as the concept of psychosis.

3.3.1 Mental health

The researcher found that the distinction between mental health and mental illness is not clear-cut. If someone is afraid of giving a speech in public, does it mean that he or she has a mental illness or simply a run-of-the-mill case of stage fright? If someone feels sad and discouraged, does it mean that he or she is just experiencing a passing case of the blues, or is it full-fledged depression requiring medication?

Various definitions for 'mental health' exist. The operational definition for 'mental health' for this research study is in agreement with *Mental Health Ireland* (2009) to be:

> … a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential. It includes being able to work productively and contribute to community life. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably, with one another and with their environment in ways that promote subjective wellbeing and optimise opportunities for development and the use of mental abilities. Mental health is not simply the absence of mental illness.

Another definition by Sands (1991:15) is that mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. She is of the opinion that the terms used in mental health are often problematic due to a lack of consensus. The researcher agrees with the definition, namely, that mental health at the simplest level is the state where there is an absence of mental illness. However, the author also notes that mental health could be viewed as an aspect of health, and therefore the state of complete physical, mental and social well-being and not merely the absence of diseases.

The terms 'mental health' and 'normality' have similar meanings but different connotations (Sands, 1991:14). Normality could suggest the average or common behaviour amongst a community, and even suggests adaptation to the social context. *Mayo Clinic* (2007) is in agreement with Sands (1991:14) and states that the person defining the state dictates what is normal. Society defines what is normal according to culture specific value judgments. When societal values or expectations change perceptions of normal mental health may change. Research may result in adjusted definitions of normal mental health.

The researcher agrees with these definitions and notes that many people have signs or symptoms of mental health disorders that neither they nor others consider an indication of a mental illness, and again some people present as completely 'normal' and do not show any evidence of signs or symptoms pertaining to mental health disorders, which might be present. It is therefore clear that a socio-cultural process intervenes between the presence of symptoms and diagnosis.

3.3.2 Mental illness

Where mental health is characterized by the absence of a mental illness, it may be acceptable to say that a mentally healthy individual does not have a psychiatric disorder, such as those in the DSM system (Sands, 1991:15;

Tilbury, 2002:1-2). According to Tilbury (2002:8), many schools and professionals have criticized the term mental illness. Various critiques came forward from statements such as "mental illness is a myth, it is not like a physical disease – you cannot catch it, have it, or transmit it". Some behaviourists objected to this medical vocabulary, labelling, and the assumption that there was an inner cause of psychological problems.

Mayo Clinic (2007) differs from behaviourist views and states that, in mental illness, signs and symptoms commonly show up as:

- Behaviours, such as repeated hand washing

- Feelings, such as sadness

- Thoughts, such as delusions that the television is controlling the mind

- Physiological responses, such as sweating

The DSM details the signs, symptoms and functional impairments that indicate specific mental illnesses. The researcher has experienced that a mental health provider can refer to the DSM to identify the illness after evaluating presented signs and symptoms. The question may be raised as to the reason why people should be diagnosed and labelled. One of the reasons may be that the health insurance industry uses the DSM diagnoses to determine benefits. Mayo Clinic (2007) however emphasizes that the decision about appropriate treatment relies on knowledge of what specific condition to treat and whether treatment is even necessary.

The researcher is of the opinion that the average person will describe mental illness as an illness characterised by highly bizarre behaviour that makes no sense to the observer. However, Tilbury (2002:7), a trained social worker in mental health, defines mental illness as:

> A person that has had a period of normality before the illness struck, and that it represents some change in an otherwise normally developing, or developed person. The diagnosis is based upon evidence that an individual is behaving, thinking, or feeling in ways which are unusual or which give him or others cause for concern. The relative importance of

disturbances of behaviour, thought or feelings will vary from condition to condition, and hence lead to the application of a different diagnostic label.

Dinitto and McNeece (1990:107-108) state that most people with serious mental illness such as schizophrenia or bipolar illness have chronic or persistent conditions; however, they lead normal lives for long periods of time and live in communities rather than in hospitals or institutions.

3.3.3 Mental disorder

The researcher agrees with Kendell (2002:111) who states that the terms mental disease, illness or disorder are roughly synonymous. Mental health disorders are better described as clinically significant behavioural or psychological patterns present in an individual. The presence of this pattern causes distress such as pain and disability and impairment to function (DSM-IV™ Multi Axial System, 2007; Kaplan et al., 1994:324; Mayo Clinic, 2007).

Mayo Clinic (2007) and Morrison (1995:8) support this definition and add a number of additional points about the criteria for mental disorders:

- Mental disorders describe disease processes, not people. Patients with the same diagnosis may be quite different from one another in many important aspects. The researcher values this point since it explicitly addresses the fears of some social workers that by using the criteria, they are stigmatizing patients.

- Professionals should not assume that there are sharp boundaries between disorders or between any disorder and 'normality'. For example, the DSM-IV refers to criteria for Alcohol Abuse and Alcohol Dependence, which are two separate disorders, but in reality, all alcohol users probably fit somewhere along a continuum.

- There is essentially no difference between a physical condition (such as diabetes) and a mental disorder (such as Bipolar I Disorder). A mental disorder could turn out to have a physical basis. The researcher can therefore understand why the multi-axial system is

regarded as so important, since it evaluates the patient on multi-functional levels.

- The DSM-IV follows the medical model of illness. This means that the DSM-IV is a descriptive book derived from scientific studies of groups of patients who appear to have a great deal in common, such as symptoms, signs, and life course of their disease.

- The DSM-IV makes no assumptions as to the aetiology (the manner of causation of a disease) of most of the disorders. This a-theoretical approach has been much praised as well as criticized.

The authors of the DSM-III-R attempted to address some of the definitional problems and assigned specific criteria to each psychiatric disorder to prevent the labelling of political activists and other inappropriate use of psychiatric diagnoses (Sands, 1991:17-19). They ran extensive field tests on an early version of the manual in an attempt to arrive at reliable diagnoses.

The researcher found this comprehensive definition by Sands (1991:19):

> A clinical significant behavioural or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful syndrome) or disability (impairment in one or more areas of functioning) or with a significant increased risk of suffering death, pain, disability or important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable reaction to a particular event, e.g. the death of a loved one. Whatever its original causes, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the person. Neither deviant behaviour, e.g., political, religious, or sexual, nor conflicts that are primarily between the individuals and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person, as described above.

Gaebel and Zielasek (2010:1) provide examples of some of the core mental disorders, as referred to in the DSM as affective disorders, neurodegenerative disorders, personality disorders, developmental disorders and disorders of addiction. An important statement by Gaebel and Zielasek (2010:2) is that psychotic disorders are reconceptualised and classified in order to add it as a new mental disorder classification in the future DSM-V and ICD-11. Although

there are various mental disorders, as mentioned above, the researcher is of the opinion that it is important to define and clarify the term 'psychosis' as part of the proposed DSM training programme and literature review.

The researcher is of the opinion that the term 'psychosis' needs clarification, since various mental health disorders are accompanied by psychotic symptoms. More importantly is that psychosis is not only the most common psychiatric term used, but is also synonymous with severe impairment of social and personal functioning characterized by social withdrawal and inability to perform the usual household and occupational roles (Gaebel & Zieasek, 2010:1; Kaplan et al., 1994:235). The impairment and dysfunctions are often the problems that social workers encounter in intervention, without identifying it as a possible psychosis. The researcher therefore will explain and provide brief information on the term as part of the literature study.

3.3.4 Psychosis

Gaebel and Zielasek (2010:1) and Kaplan et al. (1994:325) are of the opinion that disorders with psychosis are one of the most frequently diagnosed disorders. Although there are various other core mental health disorders, the researcher is of opinion that it is important to pay attention to the definition and characteristic of psychosis, not only for the most frequently diagnosed symptoms, but also due to the future inclusion of specific psychotic disorders in the DSM-V *(American Psychiatric Association*, [sa]).

When dealing with patients who experience thoughts, feelings and perceptions not based on reality, it is important to have some background knowledge of psychoses. The researcher agrees with Tilbury (2002:20) that it has always been accepted that psychoses are the particular responsibility of psychiatry; this is where psychiatric medicine is at its best. However, drug treatments on their own are clearly not enough: rehabilitation and dealing with the social-emotional factors which contributed to the illness, or which the illness has created, will call upon a wide range of skills and disciplines.

The researcher concludes that psychosis is a condition where the individual has one or more of the following five criteria over a specific time and as defined below (Buntting; 1991:22; East, [sa]; Kaplan et al., 1994:325; Sachs & Newdom, 1999:13; Tilbury, 2002:20):

Table 6:   Criteria for psychotic conditions

Abnormal Behaviour	Thought Form Abnormalities	Thought Content Abnormalities	Hallucinations	Affect (Emotions)
Too much activity	Loosening of thought associations	Grandiose delusions	Auditory	Amount of shown emotions
Too little activity	Incoherence	Persecutory delusions	Visual	Wrong shown emotions
Inappropriate activity		Jealous type	Gustatory	
		Somatic type	Olfactory	
			Tactile	

The researcher is of the opinion that social workers often work with clients where some of the above named symptoms are present, not only because of human dynamics, but also since these are the most frequently encountered disorders. Unfortunately, due to a lack of knowledge regarding psychosis, these patients might not be referred to the correct specialized individuals for adequate intervention and treatment (Gaebel & Zielasek, 2010:1; Kaplan et al., 1994:325).

3.3.4.1   Abnormal behaviour

Abnormal behaviour could be either too much activity or too little activity (Buntting; 1991:30; East, [sa]; Kaplan et al., 1994:304):

- Catatonic excitement: This term indicates too much activity and refers to restlessness, hyperactivity or 'wild' behaviour. This behaviour is often not goal directed and could even include aggression and/or destruction of property. The researcher believes that an individual with presence of catatonic excitement would be a person who presents for treatment, as the family is immediately aware that there is a problem

and cannot cope with the disruptive behaviour. The family member without energy or excitement will be in bed and tend to remain there. Only if this behaviour persists does it become problematic.

- Catatonic stupor: This term indicates a patient who is either mute and/or motionless. The patient will give brief answers with no elaboration and will be experienced as motionless with little or no response to people or the environment.
- Catatonic posturing or/and catatonic negativism: The patient may adopt strange postures, mannerisms or movements or/and uncooperativeness as shown by resistance to attempts or instructions to be moved.

Petersen (2009) states that description, as these above, should be used with good knowledge since catatonic excitement could be confused with hypomania (over-excitement) or mania, and catatonic stupor with a very severe depression, called a retarded depression. Catatonia therefore not only refers to schizophrenia, nor is schizophrenia the only psychosis.

3.3.4.2   Thought form abnormalities

The second criterion for a psychotic episode is when a patient presents with a thought process that is abnormal (Tilbury, 2002:20):

- Loosening of thought associations: The patient's ideas are often not linked properly so that the conversation is disjointed and sometimes does not make sense, although it could make sense from time to time.
- Incoherence: This is when the patient's speech is not making sense at all at any given time (Buntting, 1991:30; East, [sa]).

3.3.4.3   Thought content abnormalities

Buntting (1991:40) and East [sa] agree that a delusion is a fixed false belief, unshaken by rational argument and not in keeping with a person's educational, religious, social and cultural status. The researcher provides the

following four commonly known delusions as mentioned by Buntting (1991:40):

- Grandiose delusions
- Persecutory delusions
- Jealous type
- Somatic type

3.3.4.4 Hallucinations

A hallucination is an occurrence when one experiences something through the senses such as hearing or seeing something that is not there, i.e., perceptions in the absence of relevant external stimuli. East [sa] and Kaplan et al. (1994:307) explains that the senses involved are:

- Auditory (hearing) – the patient hears voices and sounds, although no one is making them. The voices could either talk to the patient, talk about another person or could even give a running commentary about what a person thinks or what he does.
- Visual (sight) – seeing things not there or not seen by other people.
- Gustatory (taste) – tasting strange tastes other people cannot taste.
- Olfactory (smell) – smelling things which other people cannot smell.
- Tactile (touch) – feeling things crawling on the skin but nothing is on the skin.

The following diagram provides an indication of the senses with regard to hallucinations:

Diagram 3:   Hallucinations
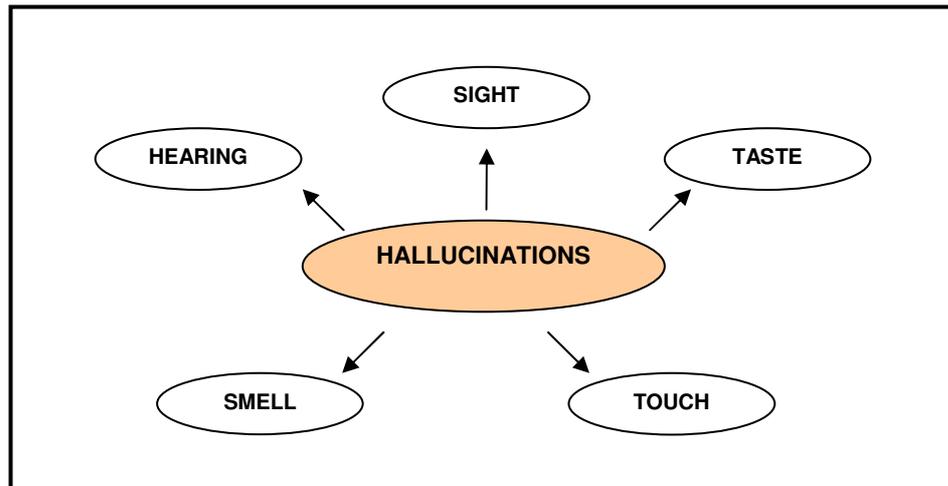
3.3.4.5   Affect (emotions)

Buntting (1991: 54) refers to two means of measuring patients' emotions.

- Blunted/Flat Emotions/Affect - when the patient has little or no emotions. These emotions show in their facial expressions or other body movements and their tone of voice.
- Inappropriate Affect - when the patient shows the wrong emotion. An example is when a patient laughs while speaking about a sad event. Excessive emotions are not indicative of psychosis as such.

The researcher believes that the people closest to the psychotic individual will recognize many of the above named symptoms, without recognizing it as a medical condition. Close family members and people that the individual knows and trusts should be involved in the individual's assessment and on-going treatment process. The input and observation of these people can provide valuable information.

Following the understanding of various terminologies in mental health, the researcher needs to define and describe the DSM-IV.

3.4 HISTORY OF THE DSM-IV

The researcher is of the opinion that is important to understand how the DSM originated and developed. According to the American Psychiatric Association [sa], the DSM has attracted controversy and criticism as well as praise. The American Medico-Psychological Association, known as the American Psychiatric Association, introduced the first American classification in 1869. However, the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I) was only published in 1952. There have been five revisions since the first publication in 1952, gradually including more disorders: DSM-II (1968); DSM-III (1980); a revised DSM-III, DSM-III-R (1987); DSM-IV (1994) and a revised DSM-IV-TR (2000) (Brubeck, 1999:122; Houts, 2000:935; Kaplan et al., 1994:309). Brubeck (1999:121) noted that even though the DSM is the creation of a psychiatric association, social workers now extensively employ the system. This author states that since the development of the US examinations for professional licensing, they have seen an increase of social workers working in the mental health field as well as a proliferation of DSM-related resources for counsellors.

There are some major changes in the international diagnostic classification systems of mental disorders, since the new edition of DSM-V and ICD-11 is on the way (Gaebel & Zielasek, 2010:1). The DSM-V is currently in consultation, planning and preparation, due for publication in May 2013 (*American Psychiatric Association*, [sa]).

The mental disorders section of the International Statistical Classification of Diseases and Related Health Problems (ICD) is another commonly used guide and the official classification system used in Europe (Kaplan et al., 1994:309). The two classifications have developed alongside each other and use the same diagnostic terminology, although the DSM is accepted as a more thorough classification system. The ICD consists of an official coding system and other related clinical/research documents and instruments (Allers, 2008; Collin, 2008, Dziegielewski et al., 2002:220; Kaplan et al., 1994:309).

The task groups with various professionals that prepared the ICD-10 and DSM-IV have worked closely to coordinate their efforts, and mutual influences, and therefore the DSM-IV is fully compatible with the ICD-10.

In 1917, a "Committee on Statistics", today known as the American Psychiatric Association (APA), together with the National Commission on Mental Hygiene, employed the first standard diagnostic categories for mental hospitals called the "Statistical Manual for the Use of Institutions for the Insane", which included 22 diagnoses (*American Psychiatric Association* [sa], Brubeck, 1999:122; Kaplan et al., 1994:309). World War II provided US psychiatrists the opportunity to work with combat veterans. This opportunity changed the psychiatric concern more to the role of the environment with less severe types of mental disturbance (Burbeck, 1999:122).

The first DSM (DSM-I) was published in 1952 and listed 106 mental disorders in a 130 page document (Burbeck, 1999:122; Grob, 1991; Houts, 2000:959). The DSM-II of 134 pages was published in 1968 and included 182 disorders. This document was similar to the DSM-I. Both documents reflected the predominant psychodynamic psychiatry as well as biological perspectives. Symptoms were not specified in detail for specific disorders. Sociological and biological knowledge was incorporated in a model that did not emphasize a clear boundary between normality and abnormality (Mayes & Horwitz, 2005; Wilson, 1993).

The first draft of the DSM-III introduced a number of new categories of disorder. DSM-III, a 494-page document listing 265 diagnostic categories was published in 1980. The DSM-III rapidly came into widespread international use and termed a revolution or transformation in psychiatry. Burbeck (1999:123) states that this publication was voted as the "the most up-to-date and valid criteria for diagnosing mental disorders and should lead to improve treatment of [social work] clients". However, Burbeck, (1999:123) also mentions that some critics were concerned about the high-inference language as well as the objective position that the manual takes. In 1987, the DSM-III-R was

published as a revision of DSM-III. Altogether, DSM-III-R contained 292 diagnoses and was 567 pages long (Kaplan et al., 1994:280).

Frances, Mack, Ross and First (2000) support Schaffer (1996) that in 1994, the DSM-IV was published, listing 297 disorders in 886 pages. This publication had major changes from previous versions especially with the inclusion of a 'clinical significance criterion' to almost half of all the categories, which required that symptoms cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning".

The American Psychiatric Association [sa] noted that a "Text Revision" of the DSM-IV, known as the DSM-IV-TR, was published in 2000. The only major changes were the text sections that provided extra information on each diagnosis, as well as some of the diagnostic codes in order to maintain consistency with the ICD.

Until late 2010, the *American Psychiatric Association* [sa] state that the DSM-V is tentatively scheduled for publication in 2012, however, according to the chair of the DSM-V Task Force, Prof. Kupfer, (Kupfer, 2010:4) this date has changed to May 2013. Kupfer (2010:4) states that various tests are needed prior to this publication. One of the field tests includes 1400 randomly selected psychiatrists and 2500 other clinicians who will examine how the DSM-V will work in a 'real life' situation. Another 3000 clinicians were approached to participate voluntarily and consist of:

- 1500 psychiatrists
- 500 psychologists
- 500 social workers
- 500 psychiatric nurse practitioners

This field test indicated that the clinician should use the draft DSM-V diagnostic criteria to assess one new patient as well as one existing patient who already received treatment from the clinician. Both the clinician and the patients will then complete questionnaires. These questionnaires are

designed to detect various diagnoses and/or symptoms that have a negative impact on the patient, and that need treatment. Kupfer (2010:4) notes that the clinicians and patients will then rate the usefulness of these measures by evaluating the:

- terms of making diagnosis
- formulation of treatment plans
- tracking the responses to treatment

The researcher found it significant that 500 social workers were approached to participate in the evaluation of the DSM-V, which is a strong indication that the author of the DSM, the American Psychiatric Association, recognises that social workers deal with the DSM. The researcher describes the multi-axial evaluation in the DSM system.

3.5 DSM-IV MULTI-AXIAL EVALUATION

The researcher experiences the DSM-IV-TR content and layout as a more user-friendly design compared to the previous editions. The introduction of this manual is followed by a brief guideline on the use of the manual. The manual provides a well-defined explanation and guideline on how to complete the multi-axial evaluation practically. Brubeck, (1999:125), Kaplan et al. (1994:330), Morrison (1995:4) and *The American Psychiatric Association* (1994:37), explain the concept of the multi-axial evaluation as five axes on which to record the bio-psychosocial assessment of the patient. The first axis is for clinical syndromes; axis II for personality disorders and mental retardation; axis III for physical disorders and conditions; axis IV for psychosocial stressors such as environmental problems and axis V for global assessment of the patient's functioning over the previous year (Brubeck, 1999:121). Saleebey (2001:185) suggests that an axis VI could be added whereby clinicians could add their own opinion with regard to the merits and strengths of clients and the resources in their environment since these resources are vital in the treatment plan.

3.5.1 Axis I: Mental disorders

Axis I records every mental diagnosis a clinical syndrome with the exclusion of the personality disorders and mental retardation (Brubeck, 1999:121; Morrison, 1995:4–5; Ruocco, 2005:1510; *The American Psychiatric Association,* 1994:38). Most of the time, a patient will have at least one Axis I diagnosis, and many will have more than one. The diagnosis primarily responsible for the current evaluation should be listed on Axis I. Clinical syndromes on Axis I were known to be characterized by transient symptoms with biological causes and unstable course. When referring to a diagnosis on Axis I and/or Axis II, the clinician must capitalize the name of the disorder according to the DSM-IV, and should read:

Axis I: 291.8   Alcohol Withdrawal

 303.90   Alcohol Dependency

The severity rating is a generic guideline that could be added after the diagnosis, should the clinician want to indicate the severity of a disorder (Morrison, 1995:5; *The American Psychiatric Association*, 1994:3–4). The researcher suggests that a social worker should rather refer to 'it seems like a 291.8 Alcohol Withdrawal' in order to emphasize the fact that it is not a diagnosis, but rather an opinion.

The following rating indicates the severity of the illness:
- Mild: Few symptoms present – other than minimum criteria needed
- Moderate: Intermediate between Mild and Severe
- Severe: Many more symptoms than the minimum criteria needed
- In Partial Remission: Previously the patient met the full criteria for the diagnosis, although some of them remain now, they are too few to fulfil the criteria currently
- In Full Remission: symptom free for a period of time that seems clinically relevant to the diagnosis

- Prior History: Appears to have recovered from the disorder, but one feels that it is important to mention it

3.5.2 Axis II: Personality disorders and mental retardation

Often when dealing with a patient, clinicians are focused on the pressing Axis I pathology, and therefore the Axis II is functional in ensuring that personality disorders and mental retardation are not ignored. Kaplan et al. (1994:315), Morrison (1995:5–6), Ruocco (2005:1510) and *The American Psychiatric Association* (1994:38–39) all explain that a patient could have more than one Axis II diagnosis. Long-standing personality traits with primarily psychological roots and a stable and unremitting course characterises personality disorders.

Common Axis II disorders include personality disorders such as paranoid personality disorder, schizoid personality disorder, schizotypal personality disorder, borderline personality disorder, antisocial personality disorder, narcissistic personality disorder, histrionic personality disorder, avoidant personality disorder, dependant personality disorder, obsessive-compulsive personality disorder, as well as mental retardation.

3.5.3 Axis III: Physical conditions and disorders

Kaplan et al. (1994:315), Morrison (1995:6), and *The American Psychiatric Association* (1994:38–39) found that a physical illness may have a direct bearing on a patient's Axis I diagnosis, for example with cognitive disorders. Physical illness may also affect the management of an Axis I or Axis II disorder. An example of such a diagnosis would be hypertension in a psychotic patient who believes that the medication has been poisoned.

3.5.4 Axis IV: Psychosocial and environmental problems

Axis IV is used to report any environmental or psychosocial event or condition that might affect the diagnosis or management of the patient (Kaplan et al.,

1994:315-316; Morrison, 1995:6). The Axis I or Axis II disorder may have caused these problems, or they may be independent events. They should have occurred within the year prior to the evaluation. If the problem occurred earlier, then the problem must have contributed to the development of the mental disorder or must be a focus of treatment. The researcher believes that social workers can add valuable information on this Axis level, since social workers are trained to focus specifically on this problem.

There are nine types of psychosocial and environmental problems according to Morrison (1995:7) and supported by Kaplan et al. (1994:316) and *The American Psychiatric Association* (1994:42–43).

- **Economic problems:** Examples are debt or credit problems, poverty, inadequate welfare or child support.

- **Housing problems**: Examples are disagreements with property owners, homelessness, poor housing, and dangerous neighbourhoods.

- **Problems with primary support group:** Examples are death of a relative, illness in a relative, family disruption through divorce/separation, remarriage of parent, physical or sexual abuse, disagreement with relatives.

- **Occupational problems:** Examples are stressful work conditions, change of job, dissatisfaction with job, disagreements with supervisor, unemployment.

- **Educational problems:** Examples are academic problems, disagreements with classmates/teacher, illiteracy, poor school environment.

- **Problems related to the social environment:** Examples are loss or death of friend, acculturation problems, racial or sexual discrimination, retirement, living alone, social isolation.

- **Problems related to interaction with legal system/crime:** Examples are being arrested, being incarcerated, suing or being sued, being a victim of crime.

- **Other psychosocial problems:** Examples are disagreements with care giving professionals (counsellor, social workers, and physician), exposure to war, and natural disasters.

- **Problems with access to health care services**: Examples are inadequate health care services, no or insufficient health insurance, unavailability of transportation to health care services.

The researcher argues that the social worker is a knowledgeable professional on this level, and can use this Axis as a guideline for intervention options.

3.5.5 Axis V: Global Assessment of Functioning (GAF)

The GAF is the last Axis, and is not a reflection of the physical limitations or environmental problems. Keet (2009:22) states in her doctoral thesis that South African Employee Assessment companies require the use of the DSM-IV's Global Assessment of Functioning (GAF) Scale in order to determine if a patient could benefit from brief counselling. The GAF score rather reflects the patient's current overall occupational, psychological, and social functioning, recorded as a single number on a 100-point scale (Morrison, 1995:7; Saleebey, 2001:183).

The GAF Scale is a global or holistic assessment of the clinician's judgement pertaining to the patient's overall level of functioning (Kaplan et al., 1994:316). The functioning is conceptualized as a composite of three major areas: social functioning, occupational functioning, and psychological functioning (Kaplan et al., 1994:316).

Table 7: GAF Scale

GAF Code	Level of Functioning	Symptoms
100-91	Superior, wide range of activities, life's problems never seem to get out of hand, he/she has many positive qualities.	No symptoms
90-81	Absent or minimal symptoms, good	Mild anxiety

	functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.	Occasional arguments with friends and family members
80-71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors, no more than slight impairment in social, occupational, or school functioning.	Difficulty concentrating after arguments Temporarily falling behind in schoolwork
70-61	Some mild symptoms, or some difficulty in social, occupational, or school functioning, but generally functioning pretty well has some meaningful interpersonal relationships.	Depressed mood Mild insomnia Occasional truancy Occasional theft within the household
60-51	Moderate symptoms, or moderate difficulty in social, occupational, or school functioning	Flat affect and circumstantial speech Occasional panic attacks Few friends, conflicts with peers or co-workers
50-41	Serious symptoms or any serious impairment in social, occupational, or school functioning	Suicidal ideation, severe obsession rituals, frequent shoplifting No friends, unable to keep a job
40-31	Some impairment in reality testing or communications or major impairment in several areas such as work or school family relations, judgement, thinking, or mood	Speech is at times illogical, obscure, or irrelevant Depressed and avoids friends, neglects family, unable to work, child frequently beats up younger children, is defiant at home, and is falling behind at school.
30-21	Behaviour is considerably influenced by delusions, hallucinations, or serious impairment in communication or judgement, or ability to function in almost all areas	Sometimes incoherent, acts grossly inappropriately, suicidal, preoccupied Stays in bed all day, no job, home or friends

20-11	Some danger of hurting self or others or occasionally fails to maintain minimal personal hygiene, or gross impairment in communication	Suicide attempts without clear expectations of death, frequently violent, manic excitement, smears faeces, largely incoherent or mute
10-1	Persistent danger of severely hurting self or others	Recurrent violence Serious suicidal act with clear expectation of death Persistent inability to maintain minimal hygiene

The researcher is of opinion that an initial GAF with assessment is valid as a measure of improvement following an intervention and summarizes the following example of a typical DSM-IV-TR Multi-Axial assessment:

Patient: Mr. A

Axis I: 291.8   Alcohol Withdrawal

              303.90 Alcohol Dependency

Axis II: No diagnosis (if none, otherwise specify the personality or retardation disorder)

Axis III: Diabetic, Regular Migraines

Axis IV: Occupational problems (change of job); economic problems (debt)

Axis V: GAF 35

The researcher is of the opinion that a social worker, who includes an Axis I-V in an assessment in a referral to another mental health provider, would use the international mental health language and such an assessment could be regarded with higher acceptance and professional merit. Social workers should however be aware of the limitations as well as the advantages of the DSM system.

3.6   DSM LIMITATIONS AND ADVANTAGES

Various aspects motivate the DSM as a good and competent classification system; however, it is also important to take the limitations and disadvantages of this system into consideration.

3.6.1 Limitations of the DSM-IV

The DSM-IV has come under various criticisms over the years, since there is no objective diagnostic test or measurement for mental illness in the field of mental health.

The following disadvantages have been argued:

i) The design of the DSM and the expansion of the criteria represent an increasing medicalisation of human nature, driven by the influence of drug companies on psychiatry. The concern for potential direct conflict of interest has been raised. Half of the authors who selected and defined the DSM-IV psychiatric disorders have or previously had financial relationships with the pharmaceutical industry. Sixty-eight percent (68%) of the DSM-V task force are reported to have ties in the industry such as holding stock in pharmaceutical companies, serving as consultants to industry or being on company boards (Cosgrove, Krimsky, Vijayoraghavan & Schneider, 2006; Kupfer & Regier, 2009:40-41).

ii) According to Corcoran and Walsh (2011:8), Gomes de Matos et al. (2005:314) and Saleebey (2001:184), a limitation of the DSM-IV is the system itself. Excessive fragmentation of each clinical state of mental disorders could be the reason why patients are often given more than one diagnosis simultaneously, since symptoms are placed in rigid categories of the manual. This may explain why many patients are diagnosed with comorbidity within an axis. The researcher agrees that there are often comorbidities, but the validity and reliability of each individual's diagnosis will be based on the clinician's clinical and professional opinion.

iii) Corcoran and Walsh (2011:8), Gomes de Matos et al. (2005:315), Saleebey (2001:184) and Spitzer, Williams, First and Gibbon [sa] identify a further limitation where the categories of all disorders refer to a list of symptoms for each disorder, such as 'panic attack' although the list does

not refer to all a patient's complaints such as dry mouth, cry outbursts, and headaches. It has been argued that purely symptom-based diagnostic criteria fail to recognise the context in which a person is living. The researcher agrees that this is the reason why the DSM system should not be used as an alone standing intervention method, but rather an assisting tool while dealing with a patient.

iv) Saleebey (2001:183) and Spitzer et al. [sa] agree that the DSM system of classification also makes unjustified categorical/symptomatic distinctions between disorders, and between normal and abnormal. The system captures common human foibles and annoying and bad habits as mental disorders (Saleebey, 2001:183). The researcher agrees that if untrained individuals utilize the DSM system, they would experience the manual as a system that labels normal behaviour as abnormal behaviour, hence the motivation for training in this field.

v) The researcher agrees with Corcoran and Walsh (2011:8), Reyneke (2008) and Saleebey (2001:184) that the DSM-V requires greater sensitivity to cultural issues and gender. The DSM-V needs to recognize the need to adopt a dimensional approach where there are cultural and gender issues in a way that better captures individuality and does not erroneously imply excess psychopathology.

vi) The last limitation mentioned by Corcoran and Walsh (2011:7-8) and Gomes de Matos et al. (2005:315) is the concern relating to the professionals using the DSM-IV. Professionals using the DSM-IV without theoretical knowledge from psychology, psychopathology and psychiatry simultaneously without adequate training and experience in practice, could result in a disaster. Many symptoms in the DSM-IV overlap different disorders. The manual intends to help acknowledge mental disorders, but it is not replacing the professional and extensive clinical assessment and diagnosis of the professional, which would result from the unique relationship between the patient and the therapist.

vii) There is an on-going debate with regard to the validity and reliability of the diagnostic categories and criteria in the DSM, regardless of the increasing attempts to standardize and improve the agreement in research for the manual (Kendell & Jablensky, 2003:6; Saleebey, 2001:184). However, it seems that the American Psychiatric Association is aiming to address this concern by setting research as a priority with regard to the DSM-V (Regier, Narrow, First & Marshall, 2002).

3.6.2 Advantages of the DSM-IV

Social workers may wonder why they should study the DSM system (Kutchins & Kirk, 1995:160). The researcher discusses the following advantages of the DSM system:

i) The use of the DSM system will lead to improved treatment of individuals. Social workers in the mental health field are responsible for making diagnostic decisions and formulate their treatment plans according to the diagnosis. This is reason enough to be familiar with the system (Brubeck, 1999:127; Corcoran & Walsh, 2011:3; Kutchins & Kirk, 1995:162; Smit, 2012).

ii) Social workers must be able to communicate with their colleagues in order to maintain a position as a respected member of multi-disciplinary treatment teams and the DSM manual is the lingua franca of mental health professionals (Brubeck, 1999:127; Corcoran & Walsh, 2011:3; Kutchins & Kirk, 1995:162; Saleebey, 2001:183; Smit, 2012). The researcher agrees with this advantage and supports Gomes de Matos et al. (2005:314) who state that the DSM system provides a 'mental health vocabulary'.

iii) The DSM system can serve as a comprehensive educational tool for teaching about psychopathology and mental disorders (Brubeck,

1999:127; Corcoran & Walsh, 2011:3; Kutchins & Kirk, 1995:162; Smit, 2012). The process of assessment will lead to diagnosis in the mental health profession. The social worker often conducts the initial assessment. Corcoran and Walsh (2011:3-4) and *The American Psychiatric Association* (1999:37) refer to the multi-axial system that involves an assessment on several axes that refers to a different domain of information that may help the social worker to plan treatment and predict outcome. The five axes classifications scheme takes into consideration all the levels of functioning, and not only the social functioning (Kaplan et al., 1994:280).

iv) Social workers will be enabled to conceptualize clients' problems (Brubeck, 1999:127; Corcoran & Walsh, 2011:3). Phares (1992:143) asserts that all people have a strong need to organize their experience systematically so that they can better deal with their world and with problems. Strong (2007) agrees with Phares (1992:143) and Anello (1989:186), who state that the DSM system is a helpful tool to assist different individuals and different professions. Gomes de Matos et al. (2005:313-314) state that previously physicians did not understand the suffering that patients had, and patients often had to endure stigmatisation and mocking if they were described as having 'hysteria' while they may suffer with panic attacks. With this system, care providers can now provide a well-interpreted opinion of a patient.

v) Social workers will establish their professional status with utilising the DSM system (Brubeck, 1999:127; Corcoran & Walsh, 2011:3). Dziegielewski et al. (2002:29) refer to previous studies by authors Kutchins and Kirk (1988:212, 1995:162) who attempted to describe social workers' opinions about the DSM-III. More than 70% believed that the DSM-III was of little assistance in treating family and marital problems. Dziegielewski et al. (2002:29) refer to a second study by Mead, Hohenshil and Singh (1994) with 550 surveyed participants (only 380 participants returned their completed questionnaires). This study, similar to the one

conducted by Kutchins and Kirk (1988:11), declared that mental health counsellors and social workers were concerned about 'labelling' their clients with a diagnostic assessment. Comparing these studies to the more recent study conducted by Dziegielewski et al. (2002:34), the changes in the acceptance of the DSM can be observed, since participants reacted positively to the manual. One response was "I can see the relationship between the DSM and what I do to help my clients in my professional practice. Social workers should use tools such as the DSM system to provide diagnostic information to their clients."

The researcher affirms that to feel comfortable with a system means to know the weak points and criticisms. Huyssen (1999:12-13) states that criticisms about the DSM in general, and the DSM-IV in particular, are abundant, although few of its critics doubt the necessity of a classification system.

3.6.3 Labelling and categorizing

Social workers seem to be sceptical about the use of the DSM system due to the labelling that diagnosis may cause (Wilson et al., 2008:575). It is impossible to work through a social work journal without coming across labels for individuals such as delinquent, psychotic, character disordered, alcoholic, psychopath, sociopath, neurotic, mentally retarded and brain damaged – to name but a few. Gambrill (1983:57) professes that these are all pejorative labels. In contrast, labels at the positive end of the scale such as 'well adjusted' and 'adequate social functioning' seem tepid in comparison. Miley, O'Melia and DuBois (2009:87) emphasise that pejorative labels and stereotypes, as used within the medical model, may assign categorical meanings and prevent social workers from focusing on potential. This may restrict service delivery by focusing on pathology.

Social work uses labels in two primary ways. The first is as a shorthand term to refer to certain behaviour, for example, hyperactivity. The second, more commonly used way, is to employ labels as a diagnostic category, which

supposedly has implications about knowing what to do with the problem. In this use of a label, Gambrill (1983:58) believes that the term 'hyperactive' connotes more than a holistic identification of behaviours: it involves either a simple or a complex network of added assumptions about the person so labelled, which in most cases will be of value in altering the situation. It is therefore clear that labels could have an instrumental meaning.

Labels may prevent further thinking about a person and his or her living experience, but may also assist in understanding the person's experience and relationships based upon the work done on the different varieties of mental health difficulty (Wilson et al., 2008:571). Labels may help normalize individuals' reactions. A parent struggling to understand why a child is slow in development may consider his/her parental skills as poor and a failure. Recognition that the child has a specific developmental disability that accounts for the slow development may be a relief to the parent.

Words such as *disorders, symptoms, conditions* and *suffering from* are quite common in the DSM. Phares (1992:141) raises concerns that these words suggest that the individual is the victim of a disease process. This language can eventually lead even astute observers into a view that turns learned reactions or person-environment encounters into disease processes.

In earlier DSM editions, clinicians were able to rate the severity of psychosocial problems. Currently the DSM-IV replaces the rating scale with a checklist of specific problems, thus making greater use of the language of social workers (Gibelman, 1995:3).

Social work is one of the professions historically ambivalent towards client classification systems, and social workers have long had concerns regarding the degree of categorizing. Regardless, the most widely used classification system among clinical social workers is the DSM (Mattaini & Kirk, 1991:261). Kutchins and Kirk (1995:162) mention that, in a national survey in the USA, 31% of registered clinical social workers agreed that the DSM helps to

determine what medication is required, while 45% disagreed and 24% were uncertain. They believe that social workers rarely see individuals for whom knowing or using the correct DSM code/label solves any problem for the client, or even assists the social worker in planning what to do (Kutchins & Kirk, 1988:215).

Despite repeated attacks upon it, this psychiatric classification system has persisted for many years. Phares (1992:143) asserts that all human beings have a strong need to organize their experience systematically so that they can better deal with their world and with problems. The problem actually lies in the fact that many clinicians have come to expect too much from psychiatric classification systems. Phares (1992:144) concurs by saying that the DSM and related systems have been compelled to predict everything. Consequently, they predict nothing really well. The researcher's experience is that clinicians therefore expect the DSM to be the basis of all interventions rather than just a supporting tool. Strong (2007) agrees with Anello (1989:186) and Phares (1992:143) who state that the DSM system is a helpful tool to assist different individuals and different professions.

The development of adequately operationalized and empirically tested contextual systems of assessment remains a principal challenge for contemporary social work. The problem addressed in this research study is social workers' lack of knowledge, the nature of and utilization of the DSM system. The exact value and benefit of intensive group training in the DSM system for social workers in South Africa however needs to be explored since no data is available in South Africa to verify this problematic area.

3.7 SUMMARY

In conclusion, it seems that the DSM is the most frequently used therapeutic system for classification in South Africa in the field of psychiatry. Although the World Health Organisation recognises the ICD-10 codes as the dedicated

classification for all diseases, practitioners and service providers admitted that the DSM remains the preferred diagnostic tool to use.

This chapter discussed psychosis since it is the most common psychiatric term used. Indications are that psychosis is synonymous with poor social and personal functioning characterized by social withdrawal and inability to perform the usual household duties and occupational roles. Social workers are often first confronted with the poor social and personal functioning, and knowledge regarding psychosis would assist the social worker with their casework and assessments.

It seems that there are various arguments as to why social workers should or should not make use of the DSM. The researcher accepts that social work was historically ambivalent towards classification systems for clients. Social workers have concerns about the degree to which categorizing and labelling clients as delinquent, unemployable, schizophrenic or mentally retarded increases stigma, shape expectations and limit opportunities.

The overall conclusion of the researcher is that the knowledge of the DSM content can assist social workers in providing a much more comprehensive service. The researcher believes that social workers, who are equipped with a basic knowledge and training in the use and misuse of the DSM system, will be in a much better position for creating a diagnostic impression in their consultation process. The knowledge of diagnostic criteria can assist the social worker to enhance the overall functioning level of their clients. Often clients as well as family members can have limited information in the area of mental health diagnosis and treatment. The well-informed social worker can correct distortions and foster cooperation and referrals in the treatment plan among the treatment team professions.

The following chapter will provide the research methodology utilised for the research study.

CHAPTER 4
RESEARCH METHODOLOGY

4.1 INTRODUCTION

The purpose of this chapter is to describe the research process followed to obtain the desired data to develop, implement and pilot test a training programme in the DSM system. Neuman (2011:8) emphasizes that social research aims to find answers for questions about the social world. However, the research relies on scientific processes and evidence. The outcome of the research process supported the researcher's initial belief that a training programme in the DSM system could add value to the social work profession. Social workers in South Africa often use the DSM system in services with regard to mental health without training in the terminology and utilization of the system. In this study, the subjective belief was tested with structured research methodology, which provided objective realistic outcomes, regardless of the researcher's subjective views.

This chapter will focus on explaining how the researcher used scientific research to develop, implement and pilot test a training programme in the DSM system and sets out the research methodology regarding:

- the research goal and objectives
- the research approach (mixed method approach)
- the research design and methodology (applied: intervention research)
- the sampling strategy (population, sample method)

4.2 RESEARCH GOAL AND OBJECTIVES

4.2.1 Goal

The goal of a research study can be either for basic or for applied research. The researcher made use of applied research since the aim of applied research is to induce change in a troublesome situation (Fouché & De Vos,

2011:94; Roll-Hansen, 2009:6), therefore to solve specific problems in practice.

The **applied research goal** for this study is as follows:

> To develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system, namely the DSM system, when dealing with individuals who present with a specific disorder.

4.2.2 Objectives

Walliman (2001:21) defines a research objective as follow: "When a research problem has been identified, in order to indicate what measures will be taken to investigate the problem or provide means of overcoming it, it is necessary to formulate a definition of the research objectives." Fouché and De Vos (2011:94) are of the opinion that the objectives refer to the steps needed to reach the goal.

The study was guided by the following objectives:

- To do a literature study regarding social workers' diagnosis and assessment within the context of the DSM system
- To explore social workers' knowledge, attitude, and utilization of the DSM system
- To develop a training programme and train social workers in the utilization of the DSM
- To implement the developed training programme for social workers in the utilization of the DSM
- To measure the effectiveness of the content of the training programme in a pilot study
- To draw conclusions and make recommendations with regard to the benefit for the social work profession and to multi-professional teamwork, should social workers receive training in the DSM system.

Following the research goal and objectives, the researcher selected a research approach.

4.3 RESEARCH APPROACH

There are primarily two approaches in social science research, namely qualitative and quantitative research as noted by Fouché and Delport (2011:63), Neuman (2011:17), Punch (2005:19) and Tewsksburg, (2009:38). Durrheim (2006:47), Punch (2005:28) and Tewsksburg (2009:38) explain that a quantitative paradigm is based on positivism, which focuses on the scientific explanation that is nomothetic. Quantitative research collects data in the form of numbers and uses statistical types of data analysis. Therefore, a quantitative research approach will aim to measure the social world objectively and to test hypotheses. The authors also refer to the qualitative paradigm, which, in contrast, is based on the anti-positivistic interpretative approach. This approach focuses on research that elicits a participant's account of meaning and produces descriptive data in the participant's own written or spoken words. It therefore identifies the beliefs and values that underlie the phenomena.

Table 8 refers to the comparison of the quantitative and qualitative approaches in social research (Durrheim, 2006:47–48; Fouché & Delport, 2011:66; Garbarino & Holland, 2009:10; Neuman, 2011:17; Tewsksburg, 2009:38-39;).

Table 8: Comparison of the quantitative and qualitative approaches in social research

	Quantitative Approach	**Qualitative Approach**
Epistemological	Positivism	Phenomenology
Purpose	Cause-and-effect hypotheses regarding social reality	Construct detailed descriptions of social reality
Methods	Deductive	Inductive
Key factor	**Reliability**	**Authenticity**
Analysis	**Statistical**	**Thematic**
Suitability	**Seek to control phenomena**	**Seek to understand phenomena**
Language	Concepts are converted into operational definitions – results are numerous – statistical language	Participants' natural language is used
Design	Standardized with fixed procedures	Flexible and unique
Research Methods	Systematically, standardized	Type of observations are modified to enrich understanding
Unit of analysis	Atomistic (elements that form part of the whole)	Holistic (concentrate on the relationships between elements)
Researcher	Detached	Involved

Delport and Fouché (2011:433) suggest that a researcher must take note of the mixed method approach, an approach combined with at least one element from both the quantitative and the qualitative approach. These authors refer to four types of mixed methods; for the purpose of this study, the researcher will only elaborate on the fourth type, embedded mixed method, since this was applicable in this study.

Plano Clark and Creswell (2008:376) define an embedded mixed method design as:

> The design consists of embedding one method (qualitative or quantitative) within a larger study guided by the other method (quantitative or qualitative), having the secondary method address a different question, and using the secondary method to enhance the implementation and/or interpretation of the primary method.

For the purpose of this study, the researcher employed intervention research in the form of a combined quantitative/qualitative approach, with the embedded mixed method design.

The reasons why the researcher chose the embedded mixed method are based on the definition above, with a primary and a secondary method in this study. The primary method is based on the quantitative approach, while the qualitative approach was followed as a secondary method.

The researcher's motivation for utilizing the quantitative method as the primary method was based upon the following discussion:

- This study's hypothesis states that if social workers receive formal training in the utilization of the DSM system, it will equip them with knowledge and insight with regard to assessment of their clients. This will enhance the profession, since social workers could be able to participate in the multi-professional team with insight with regard to mental health terminology and assessments. This hypothesis has a clear cause-and-effect purpose. The ability to predict is a central value of a quantitative research study as suggested by Fouché and Delport (2011:66), Punch (2005:48) and Tewsksburg (2009:41).
- The majority of the data was obtained by closed-ended questions in the questionnaire, which limits the possible answers to those identified by the researcher as suggested by Tewsksburg (2009:44).
- The majority of the data in this study was processed into numbers and was statistically analysed, which is typical of a quantitative approach (Garbarino & Holland, 2009:7; Neuman, 2011:17).
- The study was based on an experimental design, namely the one-group pretest-posttest design, which is typical of a quantitative approach (Creswell, 2011:12; Delport & Fouché, 2011:443).

The researcher's motivation for utilizing the qualitative method as the secondary method was based upon the following:

- The study consisted of a few open questions in order to obtain more in-depth data about the respondents' personal experiences and views, and these questions are typical of qualitative research (Tewsksburg, 2009:43).
- The study focussed specifically on social workers in South Africa who work with clients on a daily basis and this unit of population is therefore a specific population, which is one of the guidelines for qualitative research (Garbarino & Holland, 2009:10).
- The open questions collected non-numerical information, typical of qualitative research (Creswell, 2011:15).
- The non-numerical information was a text analysis, symbolic of qualitative research (Creswell, 2011:15).

The researcher noted that Delport and Fouché (2011:443) state that the most important advantage of this embedded mixed method design is that the research should:

- be able to collect the two types of data concurrently, which is relevant to this study.
- be based on an established design, such as an experimental design, as with this particular study.

The following explanation for the chosen type of research is needed, after clarifying the research approach.

4.4 TYPE OF RESEARCH

It is human nature to consistently search for an understanding of the environment. Babbie (2011:33) defines research in the social sciences as a humanistic action objectively studying social reality in order to understand phenomena. De Vos, Strydom, Schulze and Patel (2011:4) add that social sciences study human and cultural activity directly and more so in the present rather than the past. Based on discussions with professionals in the field (Gunter, 2004; Olivier, 2004; Pieterse, 2004; Smit, 2012) the researcher

became aware of the need in the social work profession for more or specialized training in methods and terminology in the DSM system for client behaviour with regard to mental health assessments and diagnosis. This can thus be regarded as a relevant problem that needed to be solved.

Durrheim (2006:45) and Roll-Hansen (2009:6) emphasise that applied research aims to contribute towards practical issues of problem solving, decision-making, policy analysis and community development. De Vos and Strydom (2011b:474) and Rothman and Thomas (1994:25) assert that intervention research is an exciting new view of applied research. Intervention research grew from developmental research that denotes the development of a technology, or rather a technological item, essential to professions such as medicine, social work, and psychology and nursing. In this study, the researcher focuses on the development of a training programme in the DSM system, aimed at social workers.

Applied research is applicable for the purpose of this study, since applied research attempts to solve specific problems or help practitioners in accomplishing certain tasks. The researcher is of the opinion that the specific problem, namely that social workers utilize the DSM without training due the mental health industry that dictate the use thereof (as explained in Chapter two), should be addressed and suggests a training programme to equip practitioners with knowledge and insight.

The researcher presents this applied research using intervention research as a developmental research method. Schilling (1997:174) defines intervention research as:

> Studies carried out for the purpose of conceiving, creating and testing innovative human services approaches to prevent problems or to maintain quality of life. Social work interventions include strategies that draw on and seek to strengthen the social ties between the individual and the social environment.

This definition is supported by De Vos and Strydom (2011b:475) who state that intervention research is an intervention (which is an applied action) by a social worker (or any other helping professional) in order to improve the functioning or wellbeing of individuals, families, groups or even populations. These definitions are in line with the aim of this study, which is to apply training in the DSM system as intervention in order to improve the service delivery of social workers.

Goldenhar, Montagne, Katz, Heaney and Landsbergis (2001:617) provide a practical guideline for intervention research with the following questions:

- What types of changes are needed to enhance the target group, namely the social workers?
- What are the best ways to bring about the changes?
- What principles/theories in social work and mental health might apply in this situation?
- To what extent do the social workers understand and buy into the need for the changes?

Goldenhar et al. (2001:617) continue by stating that these questions above could lead to the development of new interventions, however to answer these questions, the researcher needs to isolate the problem of interest (and its causes) by looking into surveillance and epidemiological data.

According to Rothman and Thomas (1994:7), intervention research should consist of three main facets, although Comer, Meier and Galinsky (2004:251) state that it is not necessary to use all three facets or even all the phases of the last facet:

- **Knowledge development**: According to Rothman and Thomas (1994: 18-19) and De Vos and Strydom (2011b:475), this facet refers to the contribution of basic knowledge of human conduct. In this study, the researcher aims to explore social workers' knowledge, attitude and utilization of the DSM. The outcome will be increased knowledge about the DSM system and social work in South Africa.

- **Knowledge utilisation**: Rothman and Thomas (1994:18-19) and De Vos and Strydom (2011b:475) explain that: "Intervention knowledge utilisation aims at applying knowledge of human conduct by means of transformation and conversion of available knowledge into the application of concepts and theories relevant to the given target groups' practices." The researcher aims with this study to utilize the data in order to obtain concepts and theories relevant to social workers in practice and to utilise the knowledge to inform current practices with regard to DSM utilization.

- **Design and development**: Rothman and Thomas (1994:18-19) and De Vos and Strydom (2011b:475) explain that this last facet aims to create new methods, programmes or service systems by means of problems or process analysis, intervention design, early development, advanced development and dissemination. The research goal for this study correlates with this facet since the entire study focusses on designing/developing a programme with specific aims such as to develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system.

The researcher has explained the use of an intervention research. The next section discusses the research design and methodology.

4.5 RESEARCH DESIGN AND METHODOLOGY

Since the researcher made use of intervention research, she regarded this phase of the study as highly imperative, since intervention research has specific phases to be followed during the research process.

Neuman (2011:6) states that a research design aims to provide a plan or strategy with practical value in order to answer questions regarding social problems. Creswell (2011:4-5) describes three types of research designs, namely qualitative, quantitative and mixed method designs. The study employs embedded mixed method design with quantitative research as primary

method, as explained in point 4.3. Delport and Fouché (2011:443) state that one of the most important aspects of this embedded mixed method design is that the research should be based on an established design, such as an experimental design.

Fouché, Delport and De Vos (2011:144) refer to two types of quantitative research designs, namely experimental designs and non-experimental designs. In the context of this study, the researcher will incorporate the experimental design.

Fouché et al. (2011:144) refer to the following three types of experimental designs for quantitative research namely:

- Classical experimental design;
- Pre-experimental design, and
- Quasi-experimental and special designs

For the purpose of this study, the researcher focuses on the second mentioned design, the pre-experimental design with a one-group pretest-posttest design (Fouché et al., 2011:147; Neuman, 2011:221). The purpose of a pretest-posttest design is therefore to compare groups or/and to measure the change that took place following an experiment (Dimitrov & Rumrill, 2003:159).

In this study, the researcher used only one group and conducted a pre-test before the intervention, followed by a post-test after the intervention, in order to measure the change that took place.

Diagram 4: One-group pretest-posttest design

Comparison

Pre-test → Intervention Programme → Post-test

Questionnaire **DSM-IV Training** **Questionnaire**

According to Diagram 4, the one-group pretest-posttest design is a measurement of a dependent variable when no independent variable is present. Subsequently, an independent variable was introduced, followed by a repeated measurement of the dependent variable at a later stage (Babbie 2011:287; Fouché et al., 2011:147-148; Huysamen, 1994:5).

The researcher followed an intervention research methodology. Comer et al. (2004:258) describe intervention research as "…typically conducted in a field setting in which researchers and practitioners work together to design and assess interventions". The researcher is of opinion that this study correlates with the statement above as it focuses on designing and piloting a DSM training programme for social work practitioners.

Babbie (2011:362) defines social intervention as an action taken within a social context in order to produce some intended results. Intervention research has specific phases during the research process. Fey and Finestack (2009:520) and Rogers [sa] refer to five phases, similar to Fawcett, Suarez-Balcazar, Balcazar, White, Paine, Blanchard and Embree (1994:28) while De Vos and Strydom (2011b:476) and Rothman and Thomas (1994:10-11) concur that intervention research is a phase model consisting of the following six phases:

1. Problem analysis and project planning
2. Information gathering and synthesis
3. Design
4. Early development and pilot testing
5. Evaluation and advanced development
6. Dissemination

4.5.1 Phase 1: Problem analysis and project planning

In this first phase, the researcher had to identify and analyse the problem in order to conduct the project planning. The problem should not be a personal problem, but a social problem that effects a society as suggested by De Vos and Strydom (2011b:476) and Rothman and Thomas (1994:10).

Gibelman (1995:1) cites Bob Dylan's famous words: "The times they are a-changing." The quote is especially true of the social work profession. As times change, so do the needs and expectations of the profession. The economic and socio-political environment of any country has always influenced the goals, priorities and targets of intervention, methodologies and technologies of social work. This is even more applicable to the development of social work within South Africa due to the multitude of transformation processes in the country. The researcher found that currently some social workers already use the DSM system, but without adequate training. Another group of social workers with a special interest in the field trained themselves in order to enhance their skills. The mental health of a client can however not be ignored or seen as a separate component, since it is an integral part of the client's bio-psycho-social functioning.

The researcher found that health care in South Africa is going through a process of restructuring as attempts are made to make it more accessible to the nation, especially with the predicted plans to implement a National Health Insurance for all citizens. Of the approximately 300 psychiatrists in South Africa, half practice in the public sector and therefore serve 80% of the population. The ratio of one psychiatrist per 280 000 people in the public sector compares poorly with a first world ratio of only one psychiatrist per 14 000 people. About one third of patients attending a health care facility will require some form of psychiatric or psychological treatment, often in addition to general medical treatment. Given the ratios detailed above, such treatment cannot be provided. For this reason all health care professionals, including social workers, are expected to possess basic psychiatric knowledge and to be able to apply this knowledge in local situations (Baumann, 1998:32–33).

The researcher is of the opinion that in South Africa, a country in need of National Health Insurance, a nation with diverse cultures, languages and a wide socio-economic diversity, the population experiences a disadvantage with regard to the ratio of psychiatrists when facing a mental health problem. Primary health care workers, such as social workers, who are familiar with the

language and customs of the local community, could be advantaged considerably if trained and familiarized in the understanding of mental health assessment and diagnosis.

Rogers [sa] states that in phase one the intervention and its hypothesized effects are identified. Generally, a small number of participants are recruited, and initial approximations of candidacy criteria are established. The treatment protocol is worked out, as are the specific outcome measures. De Vos and Strydom (2011b:477), Fawcett et al. (1994:27) and Goldenhar et al. (2001:619) further refer to a number of factors about which the researcher must make a decision. These factors include a formal problem formulation, such as identifying and involving individuals; gaining entry and cooperation from settings; identifying concerns of the population; analysing the identified problems; and setting goals and objectives (Rothman & Thomas, 1994:10). Rothman (1994:83) emphasizes that intervention research affects the nature of planning due to the dual intended output of a knowledge product as well as a practical product in the form of an intervention device or method.

4.5.1.1 Identifying and involving individuals

This phase focuses on the selection of a population whose issues are of current emerging interest to the individuals themselves, to researchers and to society (De Vos & Strydom, 2011b:477-478). The researcher found during a professional discussion that some social workers in private practice admitted that they had to utilize the DSM system as part of a contractual agreement with service providers, although these social workers had never received any formal training in this field. Training for social workers in the DSM system has been a point of discussion in first world countries, such as the United States, where the value of such training is under dispute; it has not however been a researched topic in South Africa (Kutchins & Kirk, 1995:160). The researcher identified and involved social workers interested in and utilising the DSM system in some way.

The researcher identified social workers in South Africa, working with clients on a daily basis, as the population. In her professional capacity working in psychiatric hospitals she experienced a need amongst social workers to understand psychiatry better since organisations expect them to refer company employees for assessment and treatment. All the social workers involved would not necessarily be familiar with this system, but the value of utilizing the system and the professional contribution could be explored.

4.5.1.2   Gaining entry and cooperation from settings

De Vos and Strydom (2011b:476) state that key informants can explain local ways to the researcher and introduce the researcher to gatekeepers who control access to the setting. Due to the researcher's current employment at four psychiatric hospitals, she has an existing contact network with various social work departments, the Medical Aids in South Africa, the South African Police Service, the Department of Correctional Services, BADISA (a church-based social welfare organization), as well as social workers in private practice. The researcher knew that the government departments would only allow their social workers to attend training if there was a formal invitation with an outlined programme. She sent the formal invitation to all the social workers on the her database, as well as the registered social workers in the Western Cape Province as listed in the *South African Council for Social Service Professions Resource Book* (SACSSP, 2007b).

Gunter (2004), Pieterse (2004) and Smit (2012) stated that they had to utilize the DSM system in South Africa without formal training as part of their agencies' service requirements (Keet, 2009:22). However, they did receive weekly supervision from their peers. This situation caused some confusion and negativism amongst non-trained professionals towards the manual. They were of the opinion that a training programme would grant a positive growing opportunity, and the researcher would therefore find it easier to have access and cooperation from social work settings.

De Vos and Strydom (2011b:478) state that the key informants can explain local ways to the researcher and introduce the researcher to gatekeepers who control access to the setting. Contact, communication and conversation with the key informants will help the researcher understand what they have to offer and how to articulate the benefits for the potential respondents and members of the group. A successful research intervention is based on a collaborative relationship with representatives of the setting by involving them in identifying problems, planning the project and implementing selected intervention. Initial discussions between the researcher and the social workers working with mental health related issues provided collaboration opportunities.

4.5.1.3   Identifying concerns of the population

De Vos and Strydom (2011b:478) are of the opinion that intervention researchers choose a population with whom to collaborate whose issues are of current interest to clients themselves, to researchers and to society. The researcher initiated this study since the organisation that she worked for expected her to use the DSM system, regardless of knowledge and training in this system. The researcher also approached various other professionals for their input and guidance to obtain more views on this matter.

Garb (1998:39) notes that the DSM is the classification system for mental disorders used most often in the world. Huyssen (1999:11) is of opinion that it is also the mostly used system in South Africa. This fact causes more confusion since it seems that only a small portion of social workers in South Africa is familiar with and comfortable with the system, due to the lack of training in any diagnostic system.

The researcher therefore observed controversy regarding social workers' views, knowledge and ethical obligation to diagnose and to utilize the DSM system and found that many social workers proclaimed that it is unethical for a social worker to diagnose, while other social workers utilized a diagnostic system daily as a tool for their assessment. In the process of identifying the

concerns of the population, Sewpaul (2007) noted that she was not aware of any legislation that specifically speaks of the use of the manual by social workers in South Africa. In analysing the problem and working towards planning the intended project, the researcher felt that this discrepancy in opinions confirmed the reason to conduct such a study.

4.5.1.4   Analysing identified problems

De Vos and Strydom (2011b:478-479) and Prinsloo (2001:12) remark that the difference between the ideal and the true standing of the research problem needs to be analysed. The researcher had to raise questions such as to whom the problem was affecting and why a previous intervention could not address the problem. The researcher, in collaboration with the subject specialist at the University of Pretoria, could not find any intervention research in this regard previously conducted in South Africa.

One of the identified problems is that social workers used the DSM system without adequate training. Training could equip social workers with the knowledge and practical tools to utilize this system correctly – to the benefit of the client. Tools such as the DSM could however be dangerous if used without training (Strong, 2007).

The researcher perceived that the ideal condition pertaining to training in the DSM system would be that social workers should have formal access to this knowledge; however, the reality was that social workers did not necessarily have knowledge regarding diagnostic tools such as the DSM system. The negative consequences are that social workers may have a limited assessment scope, since they might miss certain aspects of the client's functioning regarding their mental health and behaviour. Social workers will tend to work with clients and strive to change behaviour, without the realisation that some of the behaviour may be more complicated. The researcher was concerned that nobody, not the client, the social worker, nor any other profession, is benefiting from this shortfall.

4.5.1.5   Setting goals and objectives

De Vos and Strydom (2011b:479) state that goals refer to the broad outcomes or conditions that are desired by the community of interest, while the objectives refer to the more specific changes in programmes, practices or policies that are believed to contribute to the broader goal. Prinsloo (2001:13) mentions that the goals and objectives will support the researcher in the next step since they will structure the information gathering process.

The researcher formulated the goals and objectives for this study as referred to in 4.2.1 in this chapter. De Vos and Strydom (2011b:479) and Rothman and Thomas (1994:10) mention that setting goals and objectives is the final operation of this phase, prior to gathering the information in phase two.

4.5.2   Phase 2: Information gathering and synthesis

Robey (2004:404) and Rogers [sa] refer to phase two as the phase where studies should determine early indications of the presence and magnitude of efficacy. The phase should include refining the nature of the population and the treatment protocol, and develop a manual for consistent implementation and replication (describing the intervention and the methods used to evaluate treatment fidelity are examples of highly valuable contributions).

Creswell (2011:28), Strydom (2011b:480) and Rogers [sa] suggest that the researcher use existing information sources to gather information, study natural examples and identify functional elements of successful models. A literature review usually consists of various selected empirical research studies relevant to the particular theme of the study. With intervention research, the researcher must look even beyond the literature since societal problems do not confine themselves neatly to the various human and social science disciplines. Intervention research must generate new knowledge about behavioural-environment relations and establish new linkages between concepts and

methods of various disciplines. Creswell (2011:28) emphasizes the value of using literature in a quantitative study as a basis for advancing hypotheses.

A particularly useful source of information is observing case studies and how community members face the problem being studied and even attempt to address it (De Vos & Strydom, 2011b:481; Rogers [sa]). The researcher found through discussions with social workers in private practice that they were frustrated with the DSM system, since they often had to use this system, without any training in this regard. Many of these professionals trained themselves in the basic concepts regarding the DSM system, in their attempt to utilize the system correctly.

The information specialist for Social Work at the University of Pretoria conducted a thorough search of applicable databases for existing research pertaining to the topic. The search found literature on other countries' conflict regarding the scope of practice for social work, the right to diagnose, as well as the role of social work within the field of mental health, but very little information existed for the South African context. Although it is not the ideal to compare first world countries' outcomes to the South African context, since their contextual situation regarding access to health care and health care providers, cultural beliefs and language challenges are just some of the constraints, the researcher had to rely on international resources.

A very valuable resource was the information found from experts in the field. It was the researcher's perception that regardless of the lack of written literature, experts shared the same frustrations and uncertainties, and they provided valuable information relating to the reality of the need for a training programme in the DSM system for social workers. Experts, such as social workers in private practice, psychiatrists, psychologists and nurses, admitted that the DSM system is undoubtedly a practical tool, which enhances the operational functions of a multi-professional team with one set of concepts and definitions.

The following table refers to comments made by various professionals:

Table 9:   Interviews with professionals

Professional	Field of Expertise	Comments	Date
J Mayhew	MA Psychology; in Private Practice	*"The intervention could be very beneficial, training is essential in improving people's self-confidence in using the DSM-IV."*	31/03/2004
M Pieterse	MA SW; Psychology Hons; Therapist at SANCA	*"In my eyes the DSM-IV is a subjective interpretation. I would recommend that the researcher obtain different views from different professions such as medical doctors and psychiatrists."*	31/03/2004
B Olivier	MA SW; Senior Corporate Health Consultant	*"There is a great need for this intervention – especially for the therapists in practice. Aim to explore the value that training could add to practitioners in private practice."*	31/03/2004
H Opperman	MA SW; Therapist at SANCA	*"The intervention will add value. I do not know a lot about the DSM-IV, but will find it very interesting to know much more."*	31/03/2004
C Orren	MA SW (EAP); Corporate Health Consultant	*"This intervention will be excellent. Within our company, our therapists are obliged to use the DSM-IV with minimal or no training therein. There is a significant need for in-depth training."*	31/03/2004
M Smit	BA SW; In Private Practice (associated with four psychiatric clinics)	*"Utilization and application of the DSM system is so valuable – working in a psychiatric setup. Training or supervision in the use of this system is essential. Currently that is a great shortfall."*	05/02/2007
Dr. P Strong	Private Psychiatrist	*"Very interesting field, however diagnosing is a much specialized field."*	25/03/2007
Prof V. Sewpaul	PhD; Senior Professor & Head of Department of Social Work, University of KwaZulu-Natal	*"I worked in psychiatry for a number of years and worked with a consultant who believed that all of us working in mental health should be treated equally and that all of us should know how to use the manual and to diagnose."*	12/05/2007

The researcher found that all the above professionals perceived the identified research problem as a reality in practice. This research could generate new knowledge about behavioural-environment relations within mental health and the scope of practice for social work, and therefore establish new linkages between concepts and methods of various disciplines, typical of intervention research.

4.5.2.1   Using existing information sources

Rogers [sa] and Mouton (2001:90) agree that the researcher begins with the most recent sources relevant to the research subject. This way the researcher can discover how later studies have developed around the original studies. De Vos and Strydom (2011b:480-481) explain that the researcher must look beyond literature of their particular fields, since societal problems do not confine in only one particular field. Intervention research therefore contributes not only to the discovery of new knowledge about behaviour and relations, but also to the linkages between concepts and methods of various disciplines. The researcher made use of different sources to obtain information, including scientific books, articles in professional journals, standard reference materials, research reports and dissertations, the Internet, newspapers, magazines and periodicals.

The researcher found limited literature in the South African context, although various forms of data were available at an international level. The researcher did not only obtain information from literature, but also from psychiatric professionals and psychiatric hospitals.

4.5.2.2   Studying natural examples

A particularly useful source of information is observing how a community faced with the problem under study has attempted to deal with it. Interviews with people who have actually experienced the problem (such as mental health care practitioners) or those with knowledge about the problem can provide

insight into which interventions might or might not succeed (De Vos & Strydom, 2011b:481).

In her previous position as a full-time clinician for an international wellness company, the researcher found that part of the contractual obligation in intervention with a client was to provide a suggested psychiatric diagnosis. After consultations with practitioners and experts in the clinical social work field as well as in the psychiatric field, the researcher found that the majority of clinicians contracted with this company had no training or orientation in the utilization or understanding of any psychiatric diagnostic model.

4.5.2.3   Identifying functional elements of successful models

Once all the information was gathered, the researcher analysed critical features of the programmes and practices that previously addressed the problem in question (De Vos & Strydom, 2011b:481). The researcher found research conducted in the United States by Dziegielewski et al. (2002:27) to be a valuable guideline for the research process. They also made use of an intervention strategy utilizing a pre-test and post-test design as a measuring tool. The researcher was of the opinion that this study could add value, even though it was not within the South African context.

4.5.3   Phase 3: Design

During this phase, the researcher had to design an observational system as well as specifying procedural elements of the intervention. Prinsloo (2001:16) states that the researcher must design a system that can observe incidents related to the research problem naturally. The professionals affected by the research problem had to be involved in the process in order to specify the behaviour or/and environment that needs to change.

In phase three, many types of designs are appropriate but should be experimental, in the sense that designs must entail comparisons of treatment

with no-treatment control conditions or withdrawal of treatment or other experimental conditions that permit inferences of a causal relationship between the treatment and the effect (Fey & Finestack, 2009:524; Goldenhar et al., 2001:620; Rogers [sa]).

According to Goldenhar et al. (2001:620), in intervention research the goal of the design is that the:

> … intervention made a difference, in other words the training must change the views and opinions of the social workers prior to the training; Results must be generalizable (while addressing the limitation of resources such as time, funding, etc.), which means that the results should be applicable for most social workers in the same field of practice.

The researcher designed a questionnaire to explore social workers' knowledge, attitude and utilization pertaining to mental health and the DSM system. After the intervention period, which would consist of a two-day intensive training programme in the DSM system, the respondents would complete a similar questionnaire, in order to draw conclusions with regard to the impact of the intervention.

4.5.3.1 Designing an observational system

De Vos and Strydom (2011b:482) note that in this phase the researcher "… must design a way of naturalistically observing events related to the phenomenon, as well as a method system for discovering the extent of the problem and detecting effects following intervention." Such an observational system consists of three working parts namely:

- Defining the definitions of the behaviours or products associated with the problem
- Providing examples and non-examples of the behaviours or products with the aim to discern occurrences of the behaviours or products
- Scoring instructions are prepared to guide the recording of the desired behaviours or products.

The researcher identified social workers' utilization of the DSM system, without formal training, as the first aspect associated with the research problem, and the second as the social workers' lack of knowledge regarding mental health. It was the researchers' opinion that social workers are often ignorant regarding the effect and impact that mental health problems could have on their clients' functioning. The result of the lack of knowledge to assess and address mental health issues could be that social workers rather avoided clients' mental health problems. No research within the South African context was available to confirm or disconfirm the researcher's opinion.

While in private practice conducting clinical sessions for an international wellness company, the researcher observed that a significant number of social workers were expected to provide a view on a client's psychiatric diagnosis. A need for proper training in this field was identified as an urgent requirement (Mayhew, 2004; Opperman, 2004; Orren, 2004).

Dziegielewski et al. (2002:27) identified a similar need when they conducted a six-hour group training session (pretest-posttest design) in which they explored social workers' utilization skills and comfort in using the DSM, as well as assessing the continuing education experience provided. The researcher was of the opinion that Dziegielewski et al. (2002:27) provided an ideal observational system, since they identified a similar need, and conducted similar research, although within a United States context, and not a South African context. Regardless, the researcher believed that a similar intervention focusing on the South African context could be of value.

4.5.3.2   Specifying procedural elements of the intervention

Elements of intervention procedures may become part of the final practice model as the final product of the research (De Vos & Strydom, 2011b:482). These elements can include information, skills and training and include the preparatory phase, beginning phase, working phase and termination. Based upon the literature study and the interviews with experts and service providers,

the researcher specified the elements of the intervention. To provide a holistic overview of the DSM system, the researcher decided to include the following sections in the proposed training programme:

- **MODULE 1: Mental Health**
  - 1.1 Mental Health and Mental Illness
  - 1.2 Psychosis
  - 1.3 Mental Health Classification Framework
  - 1.4 Mental Health Approach
- **MODULE 2: Mental Health Team**
  - 2.1 Social Work Scope of Practice
  - 2.2 Assessments & Diagnosis
- **MODULE 3: Department of Health**
  - 3.1 Prescribed Minimum Benefits
  - 3.2 Algorithms & Guidelines
- **MODULE 4: DSM**
  - 4.1 History of the DSM
  - 4.2 DSM Purpose
  - 4.3 Multi-axial Assessment
  - 4.4 DSM-IV-TR Classification System with V-Codes
- **MODULE 5: DSM Disorder Classification Criteria**
- **REFERENCE LIST**
- **PRACTICAL TOOLS**
  - Initial Assessment
  - FAMHA and GAF Scale
  - Substance Related Disorder Algorithms
  - Resource list

The researcher acknowledges the words of Newman et al. (2007:1044) who state:

> The profession of social work has long struggled to view human behaviour and client functioning. This effort has led to many debates about what content should be included as essential social work knowledge. The DSM of the American Psychiatric Association and its conceptualization of human

> behaviour and mental health have been lightening rods with the field for how tot conceptualize human behaviour and implement the best way to be helpful to clients and reduce social problems. Social work educators have demonstrated ambivalence about including the DSM and its view of human behaviour as preparation for social work practice.

To develop a training programme with an accompanying manual for social workers in the DSM, the researcher needed to address human behavioural issues by providing an opportunity for the respondents to obtain knowledge with regard to human behaviour, mental health regulation and practice as well as guidance with regard to utilizing the DSM, referral processes, assessment tools and disorder criteria's. The programme and manual therefore did not only focus on the DSM, but also on information that guided the respondents in order to understand the DSM.

Module 1 was based on the literature study as referred to in Chapters 2 and 3. This module clarified the difference between mental health and mental illness in order to understand human behaviour and mental health disorders. Mental illness received attention with regard to psychosis, taking into consideration the value of this information, as discussed in Chapter 2. The researcher addressed the criteria for psychotic conditions as well as the signs and symptoms so that the social workers would be able to identify a psychotic episode.

The next focus was on the two different mental health-coding systems namely the ICD-10 coding versus the DSM-IV-TR. The module concluded with mental health approaches in social work. The module aimed that social workers should be able to think differently about their clients, and start viewing them holistically, and not only with regard to the social component. The need to understand what a mental health disorder is to avoid confusion with a social problem, and the need to know how to approach such a client within acknowledged social work approaches were included in the content. The researcher was concerned that knowledge on the DSM alone would be

dangerous and would support concerns about 'labelling of clients' (Newman et al., 2007:1045).

Module 2 focused on the mental health team. Kerr et al. (2007:64) note that there has been a lack of research on therapeutic service deliveries by mental health teams, and the quality or the functioning of the team as a whole. They also identified a need for research with regard to training 'or the lack thereof' for mental health teams with regard to psychotherapy. It was therefore essential that the researcher included a focus on the mental health team. This module consisted of the following, related to the mental health team:

- The *South African Mental Health Care Act* (Act 17 of 2002 section 1: xvii) defining the mental health team
- The Social Work Scope of Practice in mental health with regard to the the Social Services Profession Act
- The views of South African universities with regard to social work training in mental health
- Mental health assessments and diagnosis in terms of assessment scales with information on the Functional Assessment of Mental Health and Addiction as well as discussions around diagnoses

The purpose of this module was to guide social workers to identify their role in the mental health team, and to be able to make appropriate contributions and referrals. In order to do so, social workers needed to know what they could and could not do (scope of practice), a limitation in the field of social work within South Africa, with implications for this study.

The content of module 3 included the practical implications of the regulations of mental health in South Africa with regard to the National Department of Health who regulates the Public Sector and the Private Sector with prescribed minimum benefits and algorithms (treatment plans) and how all of this impacts on social work practice in mental health. The researcher was of the opinion that it was important to discuss the treatment plans for mental health, as provided by the South African Society of Psychiatrists, since these algorithms

indicate to the possible role players what needs to be addressed with regard to various mental health disorders (Allers, 2008).

Module 4 specifically addressed the DSM, and commenced with a history of the system followed with the purpose of the system. The multi-axial structure received attention, especially when referring a client to another mental health practitioner. This module concluded with an outline of the 17 classifications of the DSM. The purpose of this module was to guide the respondents into what the DSM is, and what the purpose of such a system is. Insight into the multi-axial structure could assist social workers with referrals since this could be a summary of an assessment, since all other mental health team members utilize it in such a format.

Module 5 focused on the DSM disorder Classification Criteria. The researcher decided to define each of the 17 disorders and where possible, provided a short history of that disorder, the genetic role with categorising each disorder with regard to Axis I, Axis II, characteristics, causes and the DSM-IV criteria. The purpose of this module was to provide a summary of the DSM-IV criteria and experts' views to be used as a practical assessment tool.

The manual included a reference list as well as the following practical tools:
- Draft initial assessment
- Functional Assessment of Mental Health and Addiction scale (FAMHA)
- GAF Scale and Substance Related Disorder Algorithm.

4.5.4 Phase 4: Early development and pilot testing

A pilot study is defined as: "The process whereby the research design for a prospective survey is tested" (*New Dictionary of Social Work*, 1995:15). This phase consists of the process by which the intervention was implemented on a trial basis, in a shorter period, in order to assess its adequacy, quality and practicality. The pilot study determined whether the intervention – the DSM training programme – would work, and would be implemented in settings

similar to the ones in which the intervention will take place. The pilot test would help to determine the effectiveness of the intervention (De Vos & Strydom, 2011b:483).

The researcher approached five social workers, a psychiatric nurse and clinical psychologist who were not part of the main study. The pilot study was based on a prototype-training programme where the content of the entire intervention was discussed and the social workers had to identify and assess the quality of the content. The participants also had to complete the pre-test and post-test questionnaire. The pilot study would determine whether the intervention – the DSM training programme – would work effectively as an intervention programme. The researcher made some adjustments based on the outcome of the pilot study; however, the overall feedback regarding the training was positive and encouraging.

The researcher found that there were logistical implications during the course of this study, since the number of respondents increased so significantly that the venue, as provided by the researcher's employer, Life Path Health Group, a group of private psychiatric hospitals in the Western Cape, was no longer suitable to cater for and accommodate 100 individuals. The CEO of the Life Path Health Group agreed sponsorship for all the catering (beverages) for the one hundred respondents over two days at a different venue. The researcher further found that there were cost implications to the printing and distribution of the 130 pages training manual handed to each respondent.

For purposes of this study, the researcher employed the one-group pretest-posttest design, which is a form of the experimental designs (Fouché, Delport & De Vos, 2011:145-146). Dziegielewski et al. (2002:27) refer to their pretest-posttest design where they explored social workers' utilization skills and comfort in using the DSM as well as assessing the continuing education experience provided. The researcher could not access the content of this study's intervention, but decided to use a similar intervention process, focusing on the South African context. Prior to this intervention, the researcher also

conducted a pre-test to assess the respondents' knowledge and comfort in using this system and then again a post-test on completion of the training. This provided valuable information into the intensity of training /intervention needed.

The pre-test questionnaire included a section with biographical questions and another section focused on the respondents' views and utilization of the DSM system. The researcher compiled these questions based on all the integrated views and statements found in the literature, made by various experts.

The pre-test was distributed and completed on the commencing date of the training programme. The research intervention included a two-day training session designed to provide information with regard to the role of social workers using the DSM, as well as equipping participants to utilize this system, should they wanted to or be expected to do so. The training focused on the following:

- an assessment into social workers' current understanding and utilization of the DSM-IV;
- an introduction into the history and general utilization of the DSM-IV;
- an explanation into DSM-IV classifications and multi-axial assessments;
- information and assessment tools;
- practical implementation; and
- summary and evaluation.

On completion of the pre-test, the respondents were introduced to the intervention – a training programme in the DSM system.

De Vos and Strydom (2011b:485) comment that an **experimental design** helps to illustrate the relationships between the targeted conditions for change and the intervention and behaviour. The researcher selected a pre-experimental pretest-posttest design by employing the one-group pretest-posttest design. It was the researcher's aim to conduct a two-day group training intervention where social workers would receive training in utilizing the DSM system with their clients.

De Vos and Strydom (2011b:486) further state that the **data collection** from the pilot test of the intervention are analysed so that the researcher can determine when the initial intervention should be implemented and whether supplemental procedures are necessary. Durrheim (2006:51) refers to data as the basic material with which researchers work. To draw valid conclusions from a research study, it is essential that the researcher have sound data to analyse and interpret. Creswell (2011:218) states that the researcher needs to be specific about the type of data, both quantitative and qualitative, to be collected during the study.

The data collection method for both the quantitative and qualitative methods was the questionnaire, including open-ended questions (qualitative) and close-ended questions (quantitative). The following data was collected from these questionnaires:

Section A – Pre-test questionnaire: Biographical information: The researcher gathered data from all the respondents regarding the following aspects:

- their expectations for the training;
- their employment;
- qualifications;
- age;
- number of clients assessed on a monthly basis;
- reason for attending the training;
- prior training received in the DSM system, and
- the use of alternative diagnostic tools.

Section B – Pre-test questionnaire: DSM System: The researcher gathered data from all the respondents regarding the following aspects:

- current utilization of the DSM system;
- current management of mental health clients;
- knowledge regarding mental health issues;
- need for training in other mental health related issues;

- views/opinions regarding the use of diagnostic tools by social workers,
- the perception of the value that the social worker's assessment would provide to other professionals.

Section A – Post-test questionnaire: DSM Training Programme: The researcher gathered data from all the respondents regarding the following aspects:

- Does training in the DSM system enhance social work assessments?
- Would a training programme assist social workers in their profession?
- Would the respondents recommend this training programme to their colleagues?
- Recommendations regarding the course content;
- Other areas in mental health that also require training; and
- General remarks.

Section B – Post-test questionnaire: DSM Training Programme: The researcher gathered data from all the respondents regarding the following aspects:

- current utilization of the DSM system;
- current management of mental health clients;
- knowledge regarding mental health issues;
- need for training in other mental health related issues;
- views/opinions regarding the use of diagnostic tools by social workers,
- the perception of the value that the social worker's assessment would provide to other professionals.

Section B of both the pre- and post-test included similar questions, in order to make comparisons and assess any change of perception and opinions.

Creswell (2011:218) states that **analysing the collected data** occurs both within the quantitative (with numeric analysis) and qualitative (text or image analysis) approach. The quantitative questions in the pretest-posttest questionnaires were developed in such a way to enable use of a computer for

analysing the data. According to Creswell (2011:219), this is typical of the 'examine multiple levels' whereby the researcher will gather quantitative results with the quantitative questions, and then explore the phenomenon with qualitative questions.

On completion of the training in the above, the researcher included a post-test after the intervention with a similar questionnaire and checklist as the pre-test questionnaire. This post-test measured the value and necessity of such an intervention. The researcher and the Department of Statistics at the University of Pretoria jointly developed the pre-test and post-test questionnaires. The department conducted the statistical processing and analysis of all the data.

The researcher used self-administered questionnaires, developed by the researcher and the Department of Statistics at the University of Pretoria who offered statistical support. This department analysed the data and provided the processed data in a statistical order. The open questions were categorised by the researcher and themes selected with regard to the categories.

The intervention was pilot tested under actual **field conditions** (De Vos & Strydom, 2011b:486). This intervention took place in the Western Cape in the format of one training session with 100 participants over a period of two days. The Life Path Health Group sponsored a venue and beverages. The number of respondents slightly differed due to last minute cancellations, transport and work related issues.

4.5.5   Evaluation and advanced development and dissemination

The researcher did not complete the last two phases but was able to make valuable conclusions and recommendations to be able to complete the full process of intervention research. The need for further evaluation and advanced development is identified as both a limitation and a recommendation or future research.

In the last two phases, the intervention needs to be refined so that the results of the field-testing can be used to resolve problems arising from the intervention and measurement system. Repeated tinkering with the intervention assists to ensure a reliable intervention (De Vos & Strydom, 2011b:486). The researcher received valuable feedback on the intervention with regard to areas where more information was needed as well as feedback on the measurement with regard to the type of questions, the interpretation of questions and the perceptions of the respondents following the field test.

Goldenhar et al. (2001:620) note that it is important to close the intervention research loop in terms of the positive and negative findings. The findings must be reported to the intervention participants directly or in a form that is understandable. De Vos and Strydom (2011b:487) and Goldenhar et al. (2001:620) describe the focus of the last phase of intervention research as:

- **Preparing the product** where the researcher should select a brand name, establish a price for training and training manuals and ensure standards to ensure the integrity of the training (product). The researcher should identify potential markets for the intervention and create demand for the intervention.

- **Identifying potential markets for the intervention** forms part of the dissemination phase. The researcher will have to ask who will benefit from the training, which market segment is the focus group, and what type of media approach will be needed (De Vos & Strydom, 2011b:488).

- **Creating a demand for the intervention** is necessary and can be obtained by modelling where the researcher could for example request a psychiatrist/expert in the field to open the training with a topic that would interest attendees. The researcher could also create a demand; by sampling (if attendees know that there will be products, such as manuals, they are more willing to attend); and advertising whereby the researcher has to advertise not only the training, but also the modelling and sampling that accompanies the training (De Vos & Strydom, 2011b:488).

Goldenhar et al. (2001:621) summarize the phases of intervention research, by stating that if a researcher is making use of an intervention for research, the following issues should be considered:

- **The evaluative potential of the intervention:** In this regard, the researcher did a literature study to obtain information and knowledge about the potential of such training in the DSM, and this intervention was tested through a pilot study to prepare for the final training programme.

- **Inclusion of resources required to conduct the evaluation:** The researcher found that the pre-test and post-test questionnaires, developed according to literature, guided the evaluation process. The researcher asked independent professionals such as clinical social workers, clinical psychologists and psychiatrists to provide their input on the intervention, prior to the implementation.

- **Controversy over the intervention design, implementation or effectiveness:** Goldenhar et al. (2001:621) state that intervention research should have on-going links to development and implementation studies in order to have better intervention effectiveness. The researcher is of opinion that this intervention could stimulate new questions and concerns. This would be an indication of the need to maintain a cycle of intervention research whereby more comprehensive and effective studies can be conducted.

- **The intervention timelines:** The rationale for conducting the study was the identified need for more training in a mental health diagnostic system, such as the DSM. This research process would test the hypothesis. The researcher should however remember that the process of implementing such a training on a formal level would be time consuming since:
  - The controversy pertaining to the scope of practice for social workers in mental health is not clear, as discussed in Chapter 2. Any changes in this regard consist of a legislative process, since

the Social Service Profession Act 110 of 1978 should then be amended. Such changes would be time consuming and intensive.

o Only when the social workers' scope of practice is clear with regard to mental health services, medical funds will be in a position to consider social work claims on a broader scope for mental health services.

o The researcher found in Chapter 2 that social work training in a diagnostic system is also unique to each university in South Africa. Every graduate social worker from a different university will have a different knowledge base and approach due to the unique curricula. A standardized module in all the universities is ideal, but the implementation of such a process could be challenging.

The researcher concluded from the above discussion that the intervention research design would be the most appropriate design, since this intervention, the training programme, would be the first programme in South Africa of its kind and could provide a platform for more intervention research or even evaluation research, focusing on evaluating existing programmes.

The following section will provide a discussion on the research population and sampling method.

4.6 DESCRIPTION OF THE RESEARCH POPULATION AND SAMPLING METHOD

4.6.1 Research population

Neuman (2011:341) defines a research population as "the abstract idea of a large group of many cases from which a researcher draws a sample and to which results from a sample are generalized". Babbie (2011:366) specifies the population as the subjects that will be the focus point to draw conclusions. He is of opinion that in a research study one is almost never able to study all the members of the population that interest the researcher, and that is why the

researcher selects a sample. Social researchers are more deliberate in their sampling.

Strydom (2011:222) refers to a universe as all the potential subjects who possess the attributes in which the researcher is interested, while a population is the totality of persons, events, organizational units, case records or other sampling units with which the research problem is concerned. The researcher identified the population as all the social workers working with a client base in South Africa.

4.6.2 Sample Method

A sample is a smaller selection of individuals from the population (Neuman, 2011:240). Babbie (2011:178) mentions two types of sampling methods:

- Non-probability sampling includes techniques in which samples are selected in a way not suggested by probability theory.
- Probability sampling refers to samples selected in accordance with probability theory, involving some random-selected mechanism.

For the purpose of this study, the researcher used non-probability sampling, specifically purposive sampling. Neuman (2011:267) explains that purposive sampling is based on "the judgement of an expert in selecting cases, or it selects cases with a specific purpose in mind". In this study, the defined target sample will be by means of a purposeful, systematic method.

Durrheim and Painter (2006:139) refer to non-probability sampling as any kind of sampling in which the selection of elements is not determined by the statistical principle of randomness. In practice, probability samples are expensive and difficult to obtain, and so the vast majority of research in social science relies on non-probability sampling. The purposive sampling in this study would be based on the judgement of the researcher, since the researcher was looking for specific characteristics representative of or typically

attributable to the population. The criteria for the selection of participants would be:

- Social workers intervening with clients in a one-to-one therapeutic process
- Social workers based in the Western Cape

For the purpose of this study, the purposive sampling would take place through a contact list of social workers, provided by the *South African Council for Social Service Professions* (SACSSP, 2007b) as well as a personal database of social workers working for the government sector, such as South African Police Service and Department of Correctional Services. The researcher studied the lists and invited all social workers in the Western Cape, who according to this list, deal with clients on a one-to-one level, to participate in the study. Unfortunately, this list does not differentiate between social workers dealing specifically with mental health issues, and therefore the researcher approached social workers, based on her own judgement, according to the speciality fields provided on the SACSSP list.

4.7 SUMMARY

The goal of this research was to develop, implement and pilot test a programme that would train social workers in the utilization of an accredited diagnostic system such as the DSM system.

The following research objectives were formulated namely: completing a literature study regarding social workers' diagnostic and assessment tools and techniques; exploring social workers' knowledge, attitude, and utilization of the DSM system; developing a training programme in the utilization of the DSM system to social workers; measuring the effectiveness and utilization of the content of the training programme; and making conclusions and recommendations regarding the benefit of a training programme for social workers in the DSM system.

A combined quantitative/qualitative research approach was followed since methods from both approaches, with the embedded mixed method design were followed. The primary method is based on the quantitative approach (close-ended questions), while the qualitative approach (open-ended questions) was followed as a secondary method. .

This research is applied intervention research since the aim of the entire study was to contribute towards the practical issue, namely social workers who either use the DSM system without training and social workers who have a need to be more knowledgeable regarding the DSM system.

The respondents would attend a two-day training programme in the DSM system. Prior to the commencement of the training, the respondents had to complete a pre-test questionnaire in order to assess their knowledge, attitude and utilization of mental health and the DSM system. After two days, on completion of the training programme, the respondents had to complete a post-test questionnaire to assess their knowledge, attitude and utilization of the DSM system after the training. This pre-experimental design, namely the 'one-group pretest-posttest design' enabled valuable interpretations and comparisons regarding the impact and value of the training programme.

The research methodology was based on the six phases of an intervention research process. In the first phase, the researcher identified the research problem, namely social workers using the DSM system, without training, and the need amongst social workers for more knowledge regarding mental health. This phase also focused on the project planning, where the researcher not only identified and involved social workers, but also received cooperation from departments such as the Social Work Departments of the South African Police Service and Department of Correctional Services, as well as various private institutions.

The second phase of an intervention research process focuses on the gathering of information. Very little literature exists regarding this field of study,

especially within the South African context. Experts in the field, such as social workers in private practice, clinical social workers, clinical psychologists and psychiatrists were approached for their expert view and guidance regarding this subject.

Within the third phase, the researcher addressed the research design, namely the one-group pretest-posttest design, for which an observational system was developed. The researcher developed a training programme in the DSM system for social workers. The intervention design, the programme and the quantitative data capture methods and questionnaires were tested in the pilot study with various experts in the field to assess the adequacy, quality, and practicalities of the training programme. In pilot tesing the training programme, the researcher collected data pertaining to biographical information, the DSM system, the DSM training.

The research population was all social workers working with a client base in South Africa, while the sample consisted of purposively selected social workers from the Western Cape.

CHAPTER 5
EMPIRICAL STUDY, DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

Chapters 2 and 3 provided a literature study on social work in mental health, and on the DSM system. This theoretical background is needed in order to reach the research goal, namely to develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system, viz. the DSM system, when dealing with individuals who present with a specific disorder. Chapter 4 elaborated on the methodology of this research and focused on the process of intervention research: a training programme was developed and presented as a pilot study. Changes were made, and then the training programme was presented to the respondents with a pre-test questionnaire and post-test questionnaire to pilot test the intervention. Chapter 5 will provide the findings from the empirical study.

Seventy-nine (79) social workers attended a training course on the first day, while seventy-five (75) attended the second day of training in the utilization of the DSM system. Each attendee received the following prior to the commencement of the training:

- Pre-test questionnaire: Section A focused on the respondent's learning experiences and biographic details. Section B focused on the respondent's view/opinion of the DSM system prior to the training.

The attendees received the training programme (exposure to intervention). On completion of the training, each attendee again received the following:

- Post-test questionnaire: section A focused on the respondent's views and/or opinions of the DSM system following the training.

Herewith the data analysis for the pre-test questionnaire, divided into section A and section B.

5.2 PRE-TEST QUESTIONNAIRE – SECTION A: LEARNING EXPECTATIONS AND BIOGRAPHIC DETAILS

5.2.1 Qualitative data on the respondents' learning expectations

The following empirical data are the learning expectations expressed by respondents as obtained from an open question in the pre-test questionnaire. The researcher has categorized the responses as follow:

Learning expectations

Each respondent listed an expectation in the open-ended question, with the exception of seven respondents that had no comment on this question. The researcher categorised all the expectations as follow. The digits before every comment are the respondent numbers:

Knowledge of assessment and diagnostic tools
- 001: "To empower myself with knowledge with regard to assessment and diagnostic methods."
- 006: "To use the correct mental health measurement scales."
- 009: "To do scientific evaluations to be more accurate in referrals to medical professions."
- 016: "To implement the correct skills/tools in order to assist the client and to draw an action plan."
- 027: "Increase knowledge base by learning new skills/assessment techniques."
- 032: "As a social worker to gain sufficient knowledge about the assessment tools identification and correct referral procedures, to expand knowledge about mental disorders."
- 045: "Accurate assessing – to work faster. To provide a better service delivery."

- 046: "To obtain more knowledge which would allow me to improve service delivery."

- 048: "Resources to assist with assessments."

- 081: "More knowledge. To be able to improve my assessments with the elderly and to motivate myself."

Knowledge of DSM system

- 002: "How can I use the DSM more effectively in social work practice."

- 003: "Learn to use the DSM IV more."

- 004: "To gain more/new knowledge and latest information about DSM IV."

- 017: "To gain more knowledge on how to use the DSM IV."

- 019: "More about the DSM and how to more effectively apply it."

- 020: "To learn more about using DSM: to apply in my work area when assessing patients."

- 021: "Using the DSM as an assessment tool and diagnostic tool."

- 025: "To use the DSM effectively and professional in the workplace. To use the DSM to such an extent to contribute to assessment and treatment."

- 035: "Enhance assessment skills. More knowledge regarding DSM as I did not had psychology III during my training."

- 038: "Learn more about DSM IV and how to use it effectively."

- 043: "To have a better understanding of the DSM IV. I'm part of a multi-professional team and the psychologist normally refers to the DSM IV."

- 052: "Regarding the clinical use of the DSM – with all its facets."

- 053: "To use the DSM IV better and understanding of it."

- 054: "Understanding of the DSM system and how to use it effectively."

- 057: "To see how using the DSM IV can assist in the work that we do (child abuse) an assist in more appropriate referrals."

- 058: "To gain understanding of how to use the DSM manual in helping clients with mental problems."

- 059: "More about DSM IV and how/were to make referrals."

- 060: "Better assessment of clients' parents/guardians with regard to DSM IV."
- 071: "How the DSM IV is used and can help me in my practice."
- 072: "Hope that social workers would be better equip to assess mental health patients since is it is a huge part of my work."
- 074: "How to use the DSM as an assessment tool."
- 076: "How to use the DSM as well as more information on the DSM."
- 090: "A touch-up course in DSM-IV."
- 091: "To learn and understand DSM-IV."
- 092: "More about how to work with the DSM as social workers."
- 096: Using and understanding the DSM IV."
- 099: "Application of the DSM IV."

Clarity on mental health issues
- 008: "How to better assess psychiatric conditions in clients in order to appropriately refer them."
- 015: "To distinguish between a person's personality and psychiatric diagnosis. Refrain from labelling. What is a reality, what can/must be changed."
- 028: "Referral system, when and when not to refer a patient based on the clients' behaviour."
- 029: "To learn more about the mental disorders of man kind."
- 039: "More clinical knowledge."
- 040: "Help to assess clients with mood problems."
- 042: "Refresh my micro/clinical skills."
- 044: "More about mental disorders."
- 055: "To learn more about mental illness assessment as well know my duties and responsibilities and when where to refer clients."
- 056: "To gain a better insight into diagnosing clients/recognizing more symptoms to make a referral for an assessment to be done by a psychiatrist."
- 061: "Gain knowledge to learn more about mental health disorders and how to do a proper assessment."

- 062: "To learn more about assessment of mental disorders and intervention."
- 064: "To be able to make appropriate assessment and be able to identify possible disorders and to be able to recommend appropriate intervention. Gain insight on various disorders."
- 065: "Ability to make a diagnosis."
- 070: "To be recouped with psychiatric information."
- 073: "I wish to learn how to do a proper assessment on mental disorders and the right referral procedures."
- 075: "Knowing exactly how to assess a person with mental illnesses."
- 077: "How to intelligently diagnose whether there mental disorders is in order to make the relevant referral/intervention."
- 078: "To learn more about mental health and how social work link with it."
- 079: "How to make accurate diagnoses."
- 080: "How to pick up indications of psychiatric illness early in intervention."
- 083: "To be able to use this method to test for mental disorders."
- 084: "To know more about mental health and mental illness."
- 085: "Gain more insight on mental disorders."
- 086: "More about mental wellness, how to apply and assist in treatment."
- 088: "Learn more about different types of personalities to assess clients."
- 093: "Clear guidelines in assisting clients with possible mental disorders. Recognition of mental disorders."
- 094: "Om mere insight the kry in 'n geestelik toestand."
- 097: "To link children's court investigations with mental health wellbeing."
- 100" "A greater understanding of the different mental health issues"

Other
- 063: "Improve knowledge."
- 067: "More information."
- 082: "Information on practical tools."
- 087: "Anything that will increase my knowledge with regard to assessments."
- 089: "Something new."

Based on all these above-mentioned answers, the researcher would summarize the learning expectations as a need for:

- o Knowledge of assessment and diagnostic tools
- o Knowledge of the DSM system
- o Clarity on mental health issues

The invitation to this training course is attached as an appendix to indicate that the course was not advertised in a biased way in order to shape the expectations of the respondents. The invitation indicated that the training would focus objectively on mental health, diagnostic tools and in particular the DSM IV. The invitation was formulated with the fact that not all social workers receive training in mental health as part of their pre-graduate training, in mind. This relates to the identified need for more training in this area, since social workers have to work with mental health patients, regardless of their training or lack thereof (Gunter 2004; Pieterse 2004; Smit 2012).

5.2.2 Quantitative data on the biographical details

➢ **Career sectors**

Figure 1:   Career sectors
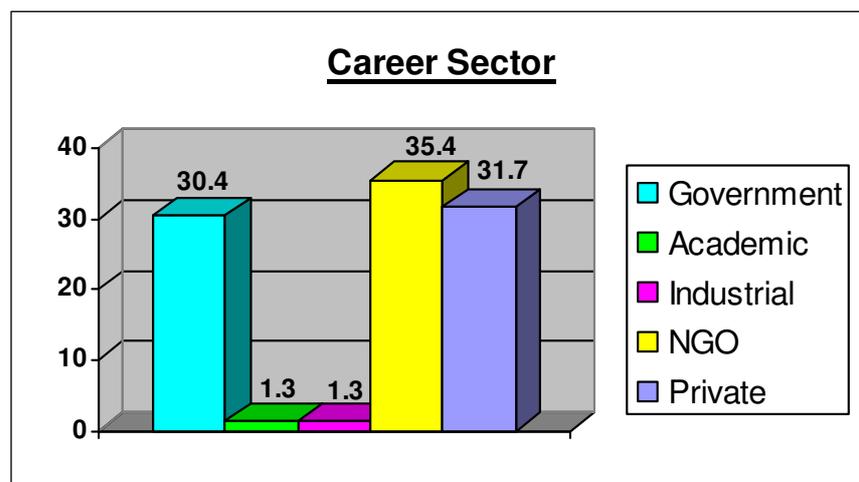
Twenty-eight (35.4%) of the respondents worked for non-governmental organizations (NGOs), while twenty-five (31.7%) respondents worked in private practice and a further twenty-four (30.4%) were employed by the government.

The high percentage of private practice social workers was unexpected, since SAASWIPP (*South African Association for Social Workers in Private Practice,* 2007b) stated that there were only 249 private social work practices registered in the Western Cape in 2003. This correlates with Munson's (2002:8) opinion that there is a significant increase from year to year in the percentage of social workers in private practice.

➢ **Qualification in Social work**

The majority of respondents, fifty-nine (74.7%) indicated that they were single-degree university graduates, while fourteen respondents (17.7%) had a MA degree and six (7.6%) respondents had a diploma.

Figure 2:   Qualification in Social Work
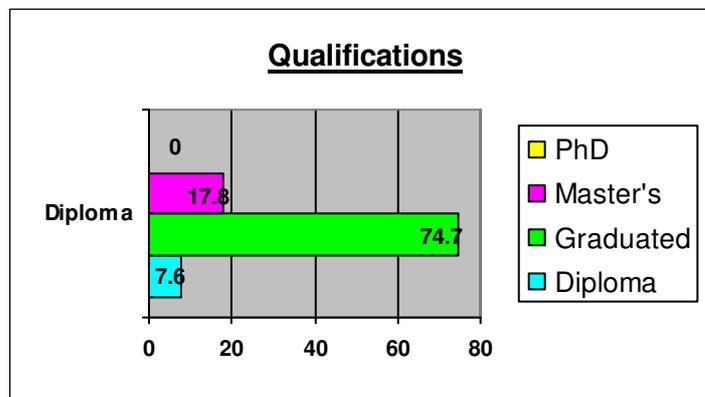
Only fourteen respondents (17.8%) of the respondents had a postgraduate qualification in Social Work, while the majority of respondents, almost fifty nine respondents (74.7%) have a 4-year social work graduation qualification as described by the South African Council for Social Service Professions (2008a). Six (7.6%) respondents had a diploma in social work.

> **Facility where qualifications were obtained**

Figure 3: Facility where qualifications were obtained
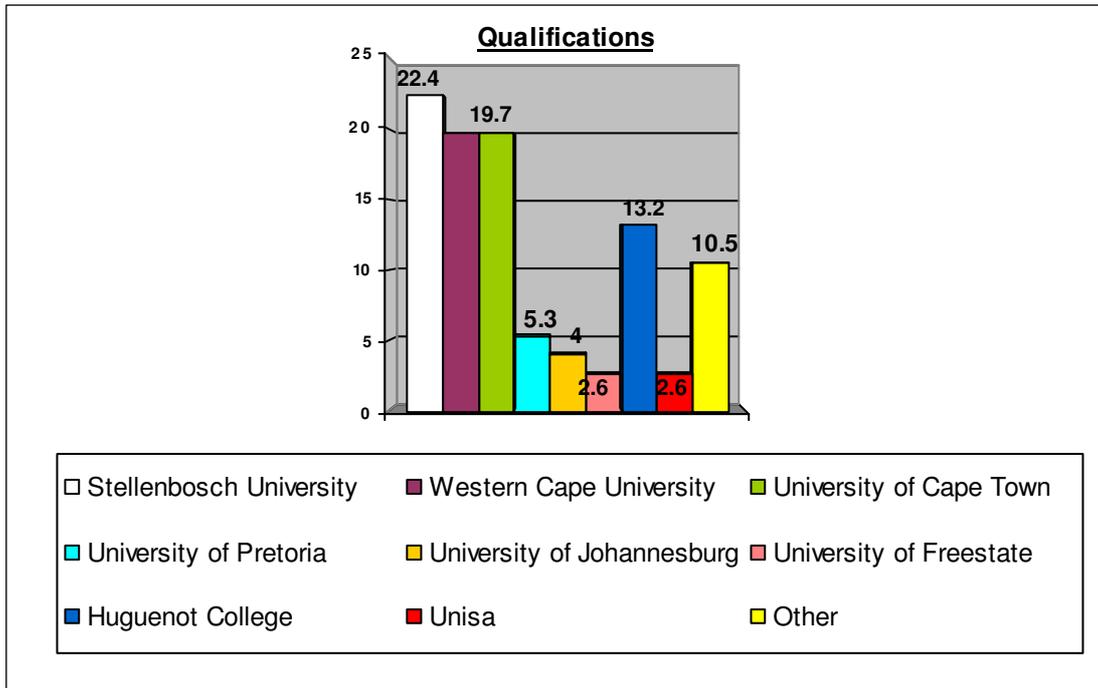
Seventeen (22.4%) respondents obtained their qualification at the University of Stellenbosch, while an equal number of respondents, fifteen (19.7%) each, obtained their qualification at the Western Cape University and at the University of Cape Town. Ten respondents (13.2%) qualified at the Huguenot College, while only four respondents (5.3%) obtained their qualifications at the University of Pretoria. Three respondents (4%) graduated from the University of Johannesburg, while two respondents (2.6%) received their qualification at the University of Free State and at the University of South Africa respectively. Other represented social workers from universities in South Africa such as Limpopo, North West, Transkei, Natal and Eastern Cape.

The geographical distribution of the respondents' academic facilities correlates with the fact that the training programme took place in the Western Cape, and therefore the majority of respondents would have received their training at academic facilities in this province, such as Stellenbosch University, Western Cape University, University of Cape Town and Huguenot College.

> **Age of respondents**

Table 10: Age of the respondents

Age of the respondents	Frequency	Percent
20–29	14	17.7
30–39	26	32.9
40–49	21	26.6
50–59	14	17.7
60–69	4	5
Total	**N=79**	**100%**

Fourteen respondents (17.7%) were younger than 29 years of age, while a large number of the attendees, namely twenty-six (32.9%) were 30–39 years of age. Twenty-one respondents (26.6%) indicated that they were 40–49 years of age, while fourteen respondents (17.7%) indicated that they were between 50 and 59 years of age. There were four respondents (5%) above the age of sixty. The majority of attendees are thus still very involved in their careers and eager to enhance their knowledge.

> **Total clients assessed per month by the respondents**

Table 11: Total clients assessed per month by the respondents

Total Assessed Clients per month	Frequency	Percent
1–8	9	11.4
10–19	19	24
20–29	15	19
30–49	14	17.7
50–69	3	3.8
70–99	5	6.3
100–260	4	5
No comment	10	12.7
Total	**N=79**	**100%**

The majority of the social workers (60.7%) responded that they assess ten to 49 clients a month. From the data above, the majority of the respondents do no more than 50 assessments per month. Four (5%) respondents noted that they see up to 260 clients per month.

These responses clearly indicate that client assessment is definitely a task done by social workers as noted by Gambrill (1983:31), as well as by Dziegielewski et al. (2002:28). The researcher notes that the reference to assessments could be confusing, since some social workers could refer to initial assessments only done once with a client in the caseload, while other could refer to every consultation done daily as an assessment. According to Karlsson (2011:10), the average monthly caseload for mental health teams varies from as low as six (6) to as high as seventy (70) per month – bearing in mind that social workers in the public sector need to travel to their patients as well. The researcher found that as Group Operations Manager for four private psychiatric clinics, the maximum number of clients per mental health team member in the private sector is six clients per day, consulted by the professional twice a month.

➢ **Clients presenting with mental health issues**

Table 12: Number of social work assessments presenting with mental health issues

Respondent	Social work assessments per month	Mental health clients per month	Percentage of mental health assessments (N=68)
001	20	20	100
003	10	10	100
004	10	2	20
005	15	10	67
006	20	2	10
007	10	10	100
008	30	10	33
009	45	0	0
010	10	5	50
011	10	10	100
012	10	10	100

013	20	20	100
015	80	80	100
016	7	6	86
017	25	22	88
018	20	20	100
019	65	30	46
021	12	12	100
022	3	1	33
023	5	4	80
024	40	25	63
025	30	10	33
026	40	30	75
028	12	4	33
029	30	15	50
030	12	8	67
031	10	2	20
032	20	2	10
033	60	5	83
034	70	25	28
035	90	25	28
036	75	25	33
037	33	8	24
038	4	2	50
040	10	7	70
041	25	4	16
042	5	1	20
043	50	10	20
044	20	10	50
045	50	50	100
046	6	3	50
047	60	52	87
048	20	20	100
049	50	40	80
052	2	1	50
053	260	10	0.40
054	8	8	100
055	40	-	0
056	20	-	0
057	20	-	0
058	70	40	57
059	25	12	48
061	28	15	54
064	40	3	75
065	10	3	30
067	13	-	0
068	180	60	33
069	160	50	31
070	160	50	31

071	10	2	20
072	10	2	20
073	28	2	7
074	15	10	67
075	30	10	33
076	10	6	60
077	20	-	0
078	30	15	50
079	15	10	67
Total	**2453**	**976**	**3436.4**
Average on N=68	**36**	**14.4**	**50.5%**

Eleven respondents (respondents 002, 014, 020, 027, 039, 050, 051, 060, 063, 063, 066) indicated that they are not doing any social work assessments, nor assessing mental health clients. For the purpose of the above comparison, the researcher did not add their data. This table indicates that the respondents, who are doing assessments, have an average of 36 assessments per month. The respondents conduct 50.5% mental health assessments from their total social work assessments. This correlates with the statement by Karlsson (2011:10) that the average monthly caseload for mental health teams varies from as low as six (6) to as high as seventy (70) per month.

The data clearly indicate that social workers have mental health clients as noted by Aviram (1997:6) Sands (1991:6) and Starinino (2009:820). These authors state that social workers often provide the bulk of mental health services.

➢ **Reasons why respondents attend training**

Figure 4: **Reasons why respondents attend training**
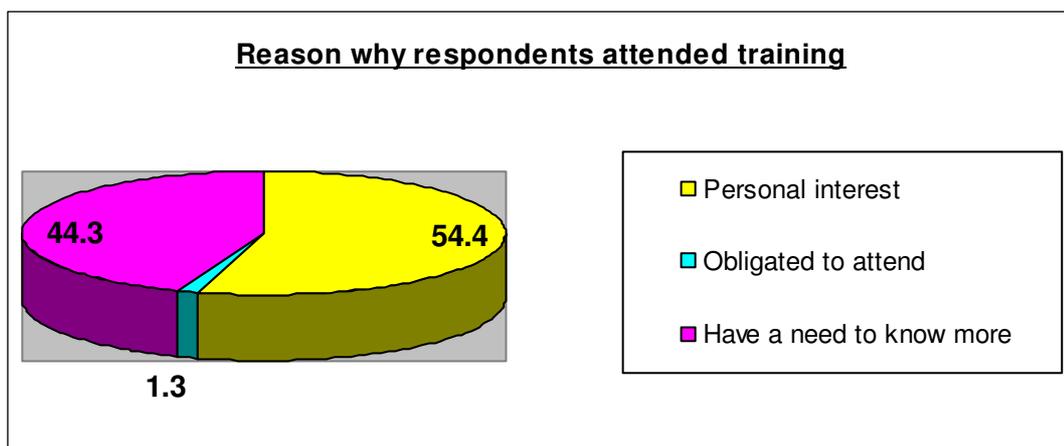
Forty-three (54.4%) of the respondents indicated that the reason for attending the training was for a personal interest in mental health, while thirty-five (44.3%) stated that they have a need to know more about the subject. The supervisor of one respondent (1.3%) identified a need and instructed the person to attend. It is encouraging that the majority of the respondents themselves identified the need to increase their knowledge regarding mental health issues and voluntarily attended the training.

➢ **Previous training in the DSM system**

Figure 5:   Did you receive any training in the DSM system?
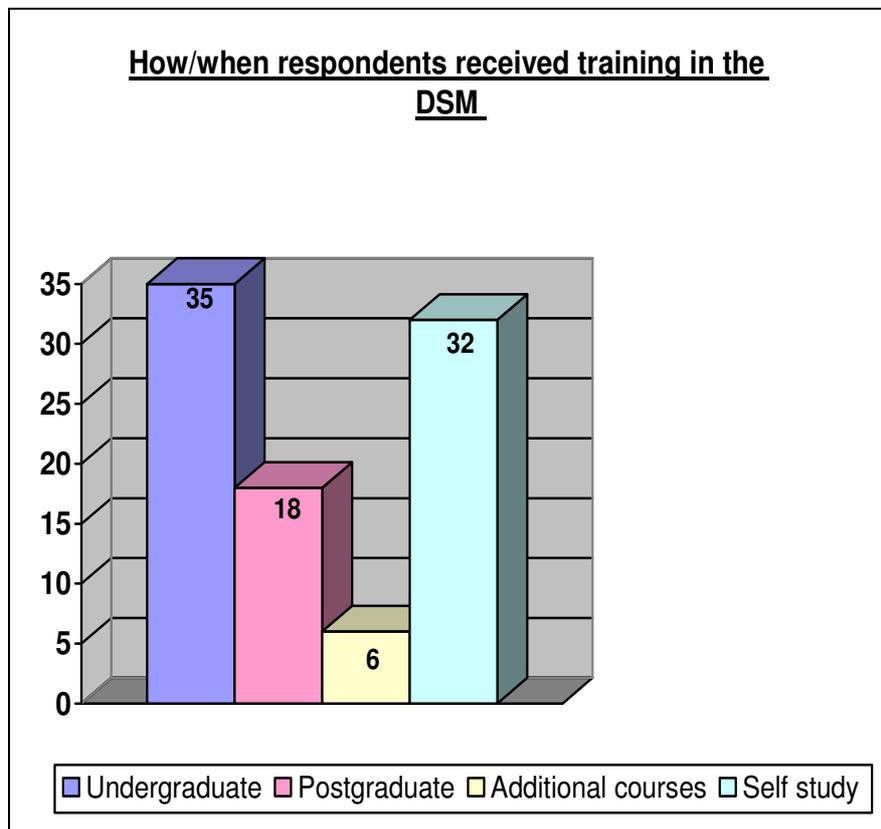
The respondents had to indicate how and when they received training in the DSM system. Twenty-eight (35%) respondents stated that they received training in the DSM system as an undergraduate student while fourteen (18%) respondents stated that they received DSM training as a postgraduate student. Only five (6%) respondents stated that they attended additional courses while

twenty-five (32%) respondents made use of self-study in order to increase knowledge in the DSM.

This data does not indicate the nature and intensity of the training; however, it indicates that training in this field is limited. It is important to note that 32% of the respondent's utilized self study as a method to obtain knowledge. This concurs with the concern of Stromwall and Hurdle (2003:211) that social work programmes must include more content with regard to mental health perspectives and language.

SUMMARY OF THE ABOVE RESPONSES

- Respondents stated that they attended the training due to a personal interest and a need to know more, which clearly indicated the need for training in this field. This statement is supported by the large number of respondents that already trained themselves either through additional courses or self-study, as well as the high turnout of participants for this training.
- Participants came from NGOs, government and private sectors, in roughly equal numbers, an indication that this is not just a need of private practitioners, but also for social workers working at grassroots' level.

5.3 PRE-TEST VERSUS POST-TEST QUESTIONNAIRE – SECTION B: DSM SYSTEM

5.3.1 Quantitative data on the DSM system

The following section discusses the comparison between the pre-test and post-test questionnaire pertaining to the DSM system.

➢ **Utilization of the DSM-IV**

Table 13: Utilization of the DSM-IV

	Pre-test Do you make use of the DSM-IV		Post-test Would you make use of the DSM-IV	
	Frequency	Percent	Frequency	Percent
Never	26	32.9	1	1.3
Seldom	17	21.5	1	1.3
From time to time	23	29.1	11	14.7
Most of the time	9	11.4	37	49.3
Always	1	1.3	22	29.3
No comment	3	3.8	3	4
Total	**79**	**100%**	**75**	**100%**

The pre-test indicated that twenty six (32.9%) of the respondents have never used the DSM system, however, only one respondent (1.3%) stated after the training that he/she would not make use of the DSM system. The training thus contributed to an increase in the number of respondents that would utilise the DSM system. Seventeen respondents (21.5%) stated that they seldom used the DSM system, while only one respondent (1.3%) felt that he/she would still seldom use the system, following the DSM training. The pre-test indicated that twenty-three (29.1%) respondent's use the DSM from time to time, but that decreased to eleven (14.7%) respondents, following the training. Only nine respondents (11.4%) used the DSM most of time prior to the training, however

thirty-seven respondents (49.3%) indicated that they would use the DSM most of the time in future.

Prior to the training only one respondent (1.3%) indicated always using the DSM system, while after the training twenty-two respondents (29.3%) stated that they would always use the DSM system. This table clearly indicates that 33 respondents (41,8%) used the DSM from time to time, most of the time and always. After the training 70 (93.3%) of the respondents indicated, they would make use of the DSM system from time to time, most of time or even always. It is important to note that the pre-test indicated actual behaviour and the post-test referred to intended behaviour.

The training in the DSM system appears to have enabled the attendees to consider the intention to use well-researched diagnostic criteria. This concurs with the view of Reyneke (2008) who referred to Ferreira who stated that the DSM system has a definite place in the training of social workers.

➢ **Management of clients with mental health issues**

Figure 6:   How do you manage clients presenting with mental health issues?
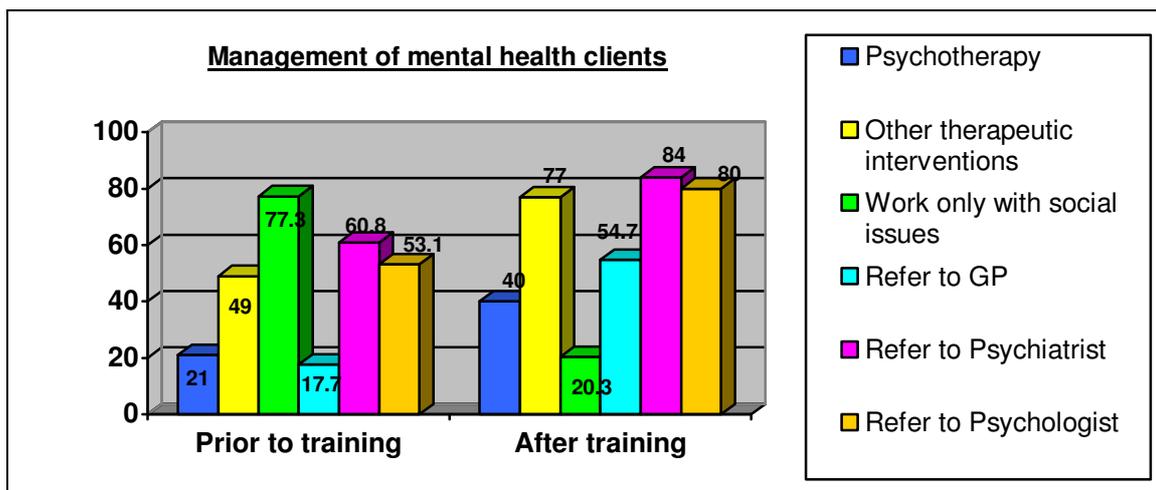
Seventeen (21%) respondents stated prior to the training that they make use of psychotherapy, while twenty-five (32%) of the respondents noted that they do not make use of psychotherapy. After the training thirty respondents (40%)

indicated they would make use of psychotherapy while forty-two respondents (56%) noted that they would still not use psychotherapy.

Prior to the training thirty-nine (49.4%) of the respondents indicated that they utilise other therapeutic interventions, while fifteen (19%) of the respondents work only with related social issues. After the training, an increased number of respondents, namely fifty-eight (77.3%) stated that they would now make use of other therapeutic interventions, while a smaller number of respondents, sixteen (20.3%) stated that they would only work with the related social issues.

Prior to the training, fourteen (17.7%) respondents stated that they refer their mental health patients to the general practitioner, while forty-one (54.7%) respondents noted in the post-test that they would refer mental health clients to a general practitioner.

Prior to the training, a high number of forty-eight (60.8%) respondents stated that they refer their mental health patients to a psychiatrist and forty-two (53.1%) also refer to psychologists. Most of the respondents, sixty-three (84%) and sixty (80%) stated that they will refer to a psychiatrist and a psychologist.

It would appear that although the attendees became aware of doing psychotherapy themselves, the training allowed them to consider other options to their current practice, viz. to use other therapeutic interventions, to deal with the client holistically and to refer mental health problems to other members of the multidisciplinary team, as suggested by Smit (2012) and Tilbury (2002:18).

➤ **Knowledge to identify mental health issues**

Table 14: Knowledge to identify mental health issues

	Pre-test		Post-test	
	Frequency	Percent	Frequency	Percent
Never	3	3.8	0	0
Seldom	18	22.8	6	7.6
From time to time	38	48.1	32	42.7

| Most of the time	17	21.5	32	42.7
Always	2	2.5	3	3.8
No comment	1	1.3	2	2.6
Total	**N=79**	**100%**	**N=75**	**100%**

Three (3.8%) respondents indicated that they never had enough knowledge to identify mental health issues, while after the training no respondents indicated that they still feel that they do not have enough knowledge to identify a mental health issue. Prior to the training, eighteen (22.8%) of the respondents responded that they seldom had enough knowledge to identify mental health issues, while seventeen (21.5%) stated that most of time they feel that they have enough knowledge. Thirty-eight (48.1%) indicated that they have enough knowledge from time to time. After the training, only six respondents (7.6%) were of the opinion that they would seldom experience that they would not have enough knowledge to identify mental health issues while thirty-two respondents (42.7%) indicated that they would have enough knowledge from time to time and thirty-two respondents (42.7%) indicated that they would have knowledge most of the time

In the pre-test, 72.1% of the respondents felt that they had enough knowledge to identify a mental health issue (from time to time, most of the time and always). An increase of 17.1% in the number of respondents namely 89.2% felt that after the training, they would have enough knowledge to identify mental health issues from time to time, most of the time or even always. It is thus clear that the training had a positive outcome, as the majority of the respondents expressed a greater confidence in their ability to identify mental health issues. The data concur with the statement made by Dziegielewski et al. (2002:34) who noted social workers' positive reactions regarding knowledge to identify mental health issues following formal training in the system.

➢ **Training needed in mental health**

Figure 7:   Training needed in various mental health areas

Prior to the training, most of the respondents, namely seventy-four (98.7%) stated that they need further training in mental health assessments, while sixty-two (82.7%) indicated that they need training in mental health disorders. Forty-nine (65.3%) of the respondents indicated that they need training in the field of mental health care. After the training, fifty-nine (78.7%) respondents indicated they needed more training in mental health assessments, while sixty (80%) indicated that they still need more training in mental health disorders. This indicates that social workers have identified a need for further training in the identification, treatment and care of mental health care users, and are willing to participate in research in order to achieve this aim to enhance their practice. The decrease in the need for further training after this training programme could be because respondents received information that would enable them to participate in multi-professional mental health teams.

The need for training in various mental health areas
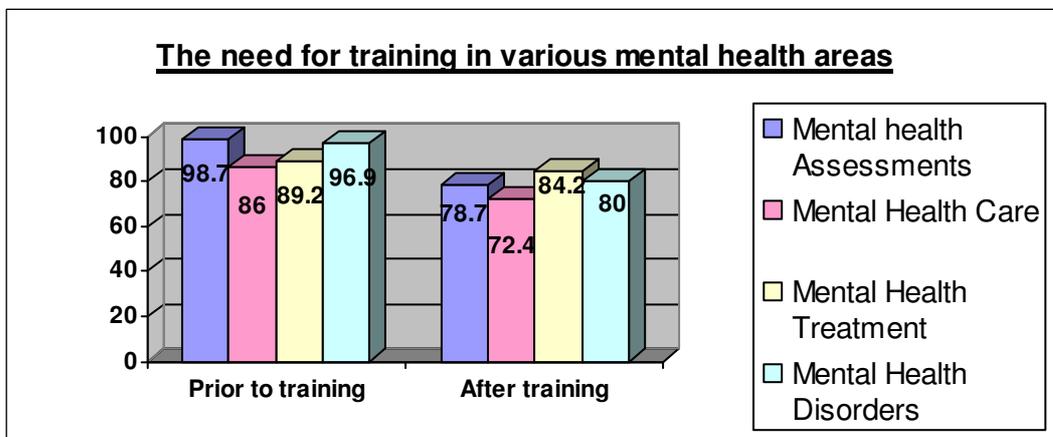
➢ **Social workers' views on diagnostic tools**

Figure 8:   Social workers' views on diagnostic tools
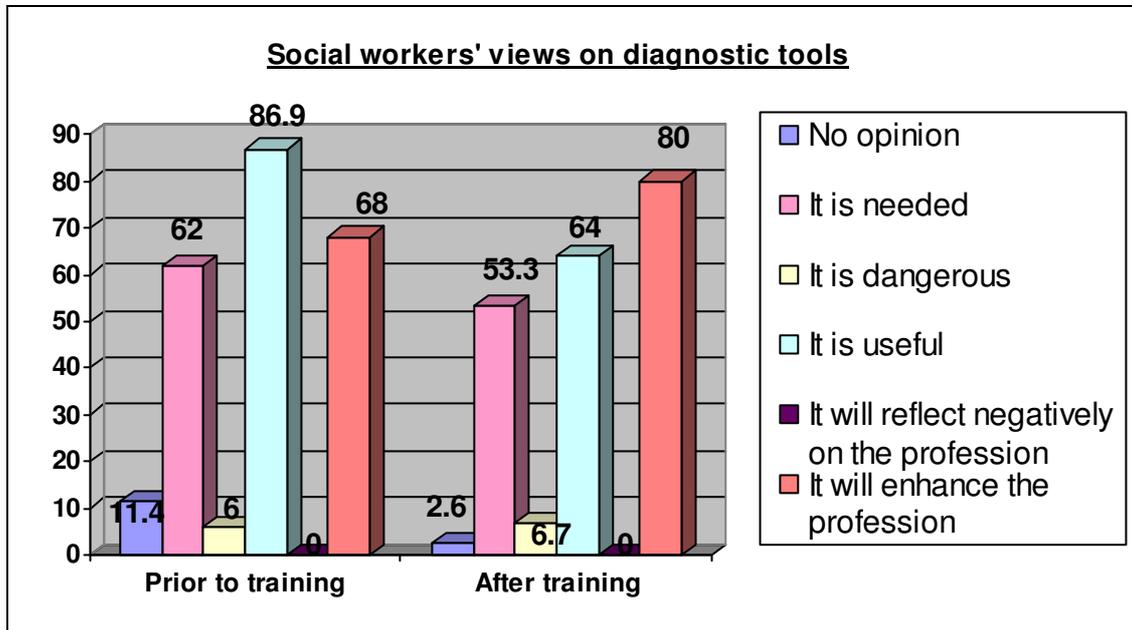
In the pre-test, only nine respondents (11.4%) stated that they had no opinion on diagnostic tools, while only two respondents (2.7%) kept that view after the training.
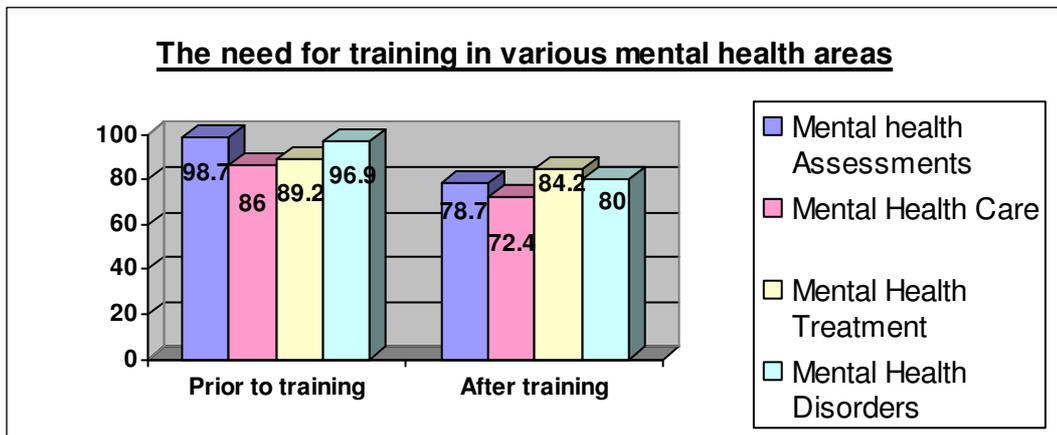
Forty-one (86.9%) respondents stated prior to the training that they feel it would be useful if social workers could use a diagnostic tool, while forty-eight (64%) stated that they would find it useful following the training. This decrease could be because respondents became aware of the complexity of the diagnostic system and that the system could not be used without proper training.

A further fifty-three (68%) stated in the pre-test that using a diagnostic tool will enhance the profession, while in the post-test sixty respondents (80%) felt that diagnostic tools will enhance the profession. Not a single respondent (0%) felt prior to or after the training that the use of diagnostic tools could result in negative reflections on the profession. Five (6%) respondents indicated in the pre-test that the use of diagnostic tools could be dangerous, while a further five respondents (6.7%) kept that view after the training. The significant increase in the number of respondents, who felt that the use of a diagnostic tool enhances the profession, was encouraging.

These responses confirm the statement made by Kutchins and Kirk (1995:160), Smit (2012) and Starinino (2009:836) who state that social workers in the mental health field are responsible for making diagnostic decisions and formulate their treatment plan according to the diagnosis, which is reason enough to be familiar with a diagnostic system. Smit (2012) and Kutchins and Kirk (1995:160) further agree that the DSM system is their preferred diagnostic tool, and that the DSM will enhance the social work profession since social workers will be able to communicate with their colleagues in order to maintain a position as a respected member of the multi-disciplinary treatment team.

➤ **Social workers' view on how other professionals value their input**

Figure 9:   Professionals' value of assessments made by social workers
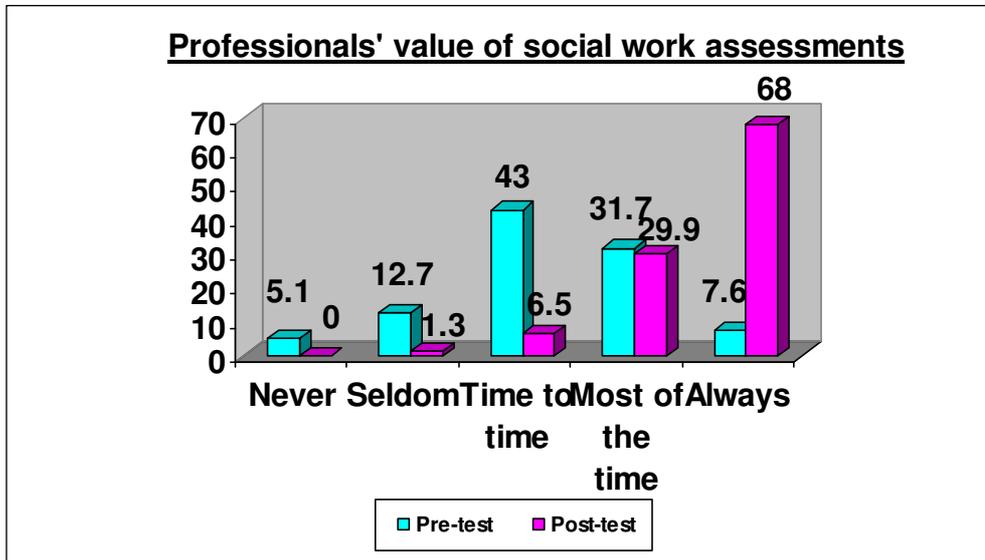
This figure indicates that the general view in the pre-test leaned towards a value level of time to time and most of time, while the post-test indicated that the respondents have changed their views and felt that other professionals could value social workers' assessments most of the time to always. The post-test showed that the majority of the respondents, namely fifty-one (68%) stated that other professionals would always value a social work assessment if the social worker was more knowledgeable in mental health.

Munson (2002:8) notes that even in the twenty-first century, people still regard social work as a type of charity organization or child welfare, which makes it understandable that social workers could have the perception that other professionals do not fully value their assessments.

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CONCLUSIONS FROM THE ABOVE

- Following the training, the respondents changed their views on the use of the DSM system dramatically from "never", "seldom" and "from time to time" to high scores on "from time to time" and "most of the time".

- A small number of respondents had a concern that the training could be dangerous. The majority of respondents were of the opinion that training in the DSM system is needed, useful and will enhance the profession.

- A small number of respondents felt that social work reports are always valued, but indicated that with more knowledge of mental health, social workers' assessments could be valued by other professionals.

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5.4 POST-TEST QUESTIONNAIRE – SECTION A: SUMMARIZED VIEW ON THE DSM TRAINING

5.4.1 Quantitative data on respondents' views on the DSM training

The quantitative empirical data refer to information obtained after the intervention took place.

➢ **Would training enhance social work assessments?**

Figure 10: Would training in the DSM system assist social workers to conduct assessments that are more professional?

Would training benefit Social Workers

	Value
Yes, with all assessments	84.4
Yes, but with limited cases	14.3
No	1.3
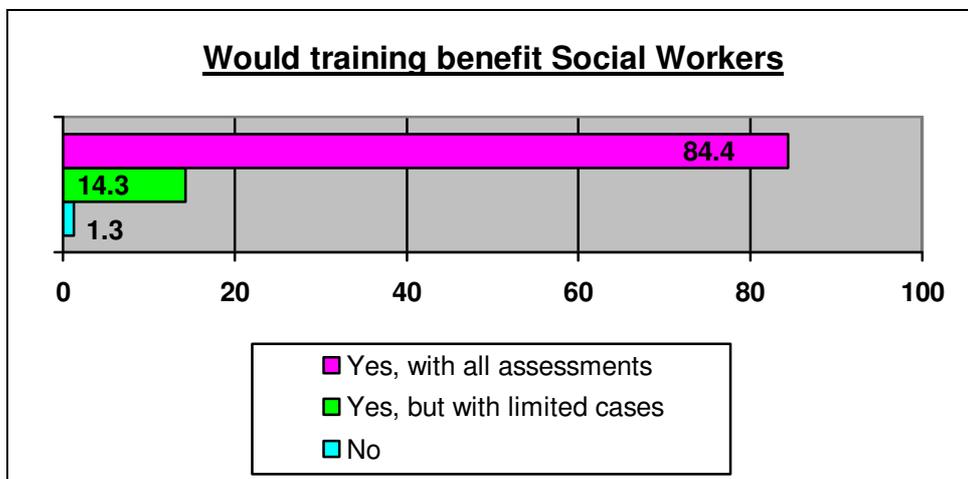
Sixty-five (86.7%) respondents stated that the training would assist them with their assessments, while a smaller percentage; eleven (14.7%) respondents noted that the training would only assist them with limited cases. There was only one (1.3%) respondent stating that the training would not assist him/her in social work assessments.

Kutchins and Kirk (1995:160) are of the opinion that social workers would benefit from using the DSM system since it will enhance the profession in terms of various factors such as:

- formulating a treatment plan, and
- to maintain a position as a respected member of the multi-disciplinary treatment team.

➢ **Will the training that you received assist you in your profession as a social worker?**

Figure 11:   Will the training assist the social worker?

Will the training assist the social worker in their profession as a social worker? (N=77)

1.3

98.7

☐ Yes   ☐ No
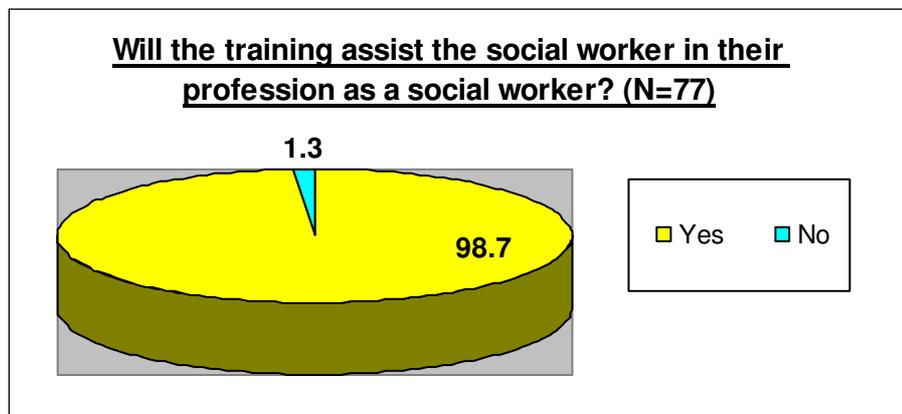
Seventy-four (98.7%) of the respondents indicated that the training they have received would assist them in their profession as a social worker, while only one respondent (2.7%) noted that she would not find benefit with this training.

➢ **Would you recommend the training to your colleagues?**

Figure 12: Would you recommend the training to your colleagues?
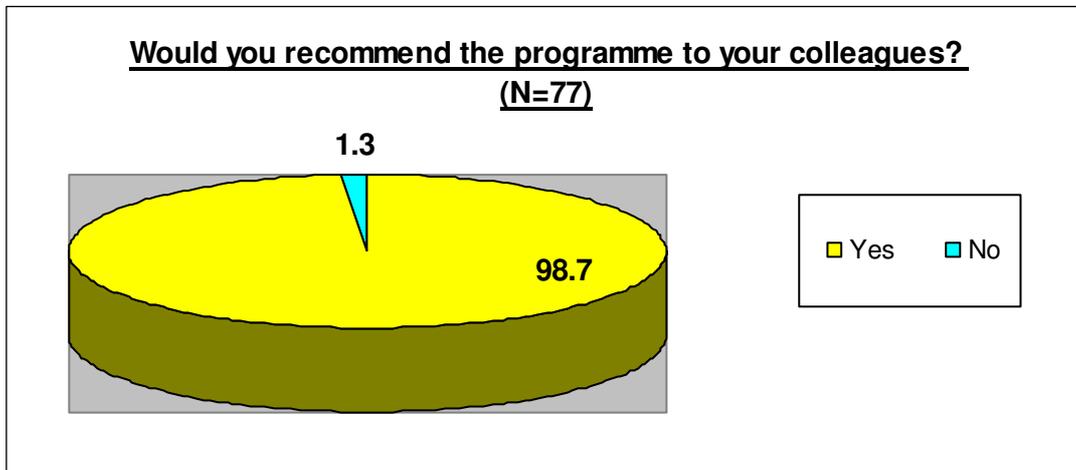
Seventy-four (98.7%) of the respondents stated that they will recommend the training programme to their colleagues while only one respondent (1.3%) noted that they will not recommend the training. The majority of the respondents found the training sufficiently beneficial to recommend to their colleagues.

CONCLUSIONS FROM THE ABOVE

- The majority of the respondents were of the opinion that training in the DSM system will benefit social workers since it will assist them to provide more comprehensive assessments, it will upgrade and empower the social work profession and it will assist social workers to develop more appropriate treatment plans.

- It is therefore understandable why all the respondents, except for one respondent (who indicated that she is in the academic field) would recommend this programme to their colleagues.

5.4.2   Qualitative data from the respondents' views on the DSM training

5.4.2.1   Reasons why the DSM training will assist social workers in conducting more professional assessments

The researcher identified the following themes from the open comments on reasons why the DSM training will assist social workers in conducting assessments that are more professional:

- **Main theme 1: Enable social workers to use mental health terminology**

Respondents indicated a need to become familiar with mental health terminology, as utilized in the context of mental health intervention. The following verbatim responses confirm the need.
  - "To use the right terminology"
  - "Will be able to speak the language of the doctors"
  - "To use the mental health language will be a great benefit"
  - "More professional language"
  - "Terminology used will enhance professionalism"
  - "Professional language that makes you more professional"
  - "Same language across the team"

- **Main theme 2: The training will enable service providers to make sooner and more appropriate referrals**

It was clear from the responses that respondents were of the opinion that training would assist them to know when and how referrals should be done. This also provided an indication that respondents were aware of the services provided by and the roles of mental health team members.
  - "Learn boundaries and when to refer"
  - "Assist with referring appropriately"

- "I will right more professional referrals"

- "Will help me to refer to the correct practitioner"

- Will make referrals sooner when needed"

- "Assist with proper referrals"

- **Main theme 3: The training would assist in making more comprehensive assessments**

  - "Provides me with means to assess my clients"

  - "Will do more in-depth assessments"

  - "Improve recognition of disorder"

  - "Will use the DSM as motivation for my assessments and recommendations"

  - "Good assessment give quality service delivery"

  - "IT gives me a reference to use in assessments"

- **Main theme 4: Upgrade and empower social work profession**

  - "It boost my confidence with knowledge"

  - "It will improve my professional image"

  - "Now my opinion could be based on a tool"

  - "It improved my social work skills"

  - "Assist me to understand clients and their disorders"

  - "I have better insight"

  - "I will be more efficient in rendering a service"

  - "it gives me confidence"

It seems from this qualitative data that the respondents felt that a DSM training programme would assist them as social workers in conducting more professional assessments. Social workers who are familiar with mental health terminology would be able to make sooner and more appropriate referrals, would be able to conduct comprehensive assessments and felt that the training would upgrade and empower them as social workers.

5.4.2.2 Reason's why the course would assist them in their profession as social workers

The researcher identified the following themes similar to the responses above, from the comments with regard to why the course would assist social workers in their profession:

- **Main theme 1: Enable social workers to use terminology**

Comments with regard to social workers who would feel enabled to use mental health terminology following the training:

- "Appropriate understanding of medical terms"
- "I can understand the terminology better"
- "Assist with referring appropriately"
- "Will be more professional due to correct terminology"
- "Assist in report writing and referring patients'
- "Better communication with other professionals"

- **Main theme 2: Social workers making referrals to the multi-professional team**

Comments with regard to social workers who could make referrals to the multi-professional team following the course:

- "To keep in mind mental health symptoms in order to make referrals"
- "Can focus on specific referrals"
- "Assist with mental health referrals"

- **Main theme 3: Comprehensive assessments**

Comments with regard to social work assessments following the course:

- "It provides me with means to assess my clients"
- "I understand better how and what to assess"

- "I feel comfortable to do an assessment"

- "Will motivate my assessments and referrals with a DSM when applicable"

- "It gives me direction on cases where I am stuck"

- "Now I can look at the client with more depth"

- "It gives me structure from which I can define certain behaviour"

- "I will be able to do more thorough assessments"

- "Now my assessments can be based on a tool"

- **Main theme 4: Empowering of social workers**

Comments with regard to social workers who feels empowered following the course:

- "Knowledge boost my confidence"

- "I feel motivated to conduct professional assessments"

- "I have more confidence to work in mental health"

- "I have a better understanding for clients"

- "I can now improve my social work skills and can be recognized in a team"

- "I realized the complexity of diagnosing and will be more cautious"

- "I feel motivated to improve the image of social workers"

- "My credibility with doctors will improve"

- "I will remember not to diagnose, but I will express my viewpoints and opinions"

From the responses of the attendees, it appears that social workers were eager to improve their knowledge and skills especially concerning mental health care issues. The research of Dziegielewski et al. (2002:28) supports this view since they note that social workers should be keenly aware and alert to updates in diagnostic criteria throughout the intervention. They state that training in a diagnostic tool would equip the social work professionals to provide better client services and provide an opportunity for the profession to recognize malpractice in terms of the DSM system.

5.4.2.3   Recommendations with regard to the course content

The researcher identified the following themes from the recommendations with regard to the course content:

- **Main theme 1: Integration of course content**

The open comments on the course content clearly indicated a need for more opportunities to integrate the obtained theoretical content in practical applications. The content was new to many respondents and the researcher recognises the need for more integration of obtained information.
  - "More case studies to be presented"
  - "More visual material such as videos"
  - "More case studies from the attendees"
  - "Case studies from a psychiatrist"

- **Main theme 2: Theoretical content of course**

Comments and recommendations included specific needs with regard to theoretical content. Respondents indicated areas where they required information that is more specific.
  - "More information on specific disorders, such as bipolar"
  - "Familiarize more on different algorithms in mental health"
  - "May have more information on the biology of the disorders"
  - "More information on patient rights against the background of human rights and the consumer movement"

- **Main theme 3: Mental health team utilisation**

Respondents became aware of the roles and services of mental health team members. Comments and recommendations included the request for more information with regard to referral of mental health clients.
  - "To discuss more referral pathways"

- "To present this course in conjunction with a psychiatrist"
- "It gave me a clear understanding of my role in mental health"
- "Gave insight to work more freely in a multi professional team"

- **Main theme 4: Duration of the course**

Comments with regard to the duration of the course were that, even though the training was over two days, a number of attendees requested more time for this training with recommendations of training up to 4 days. Only two respondents indicated that the training took too long.

- "More time needed a lot of information in short period."
- "Need more time to do in-depth studies and discussions"
- "Time needed for more difficult case studies"
- "It is too much work for two days, rather present it over two courses"

A large number of respondents indicated that the training was informative, valuable and empowering. The main recommendations for this course is that more practical integration, case studies and audio visual examples should be included; more information on specific disorders were requested; a need for discussion with regard to the team approach was expressed and various comments were made that such a training should take place over more than two days.

Respondents were social workers from various backgrounds, levels of training and expertise, and different work experiences and the researcher therefore found it difficult to address the needs of all the respondents. However, the overall comments with regard to the training were positive and encouraging.

- **Other remarks**

In conclusion, respondents could add any other remarks. The remarks were overall positive and encouraging with various requests for follow-up training. Herewith some remarks:

- "Excellent course – Thank you."
- "We need more courses like these in the social work profession to upgrade our recognition as a specialized field."
- "Good training, very useful."

CONCLUSIONS FROM THE ABOVE

- Respondents indicated that they would recommend the inclusion of more case studies, visual material and examples.
- Some respondents stated that more opportunity should be provided to practically implement the knowledge.
- Respondents recommended that the training should take place over a longer period since two days were not sufficient.
- Many comments indicated that follow-up training would be valuable.
- In general, respondents experienced the training as positive and referred to the guideline as empowering with good content and professional presentation and material.
- Many respondents stated that the training program was an excellent course, useful and informative.
- The respondents experienced the training as an enhancement to their careers that empowered them with knowledge and confidence.
- Generally the remarks were positive in the closing statements and the majority of respondents showed gratitude for the training and for the effort that went into the programme.

5.3 SUMMARY

This chapter represents the empirical data obtained from this study and consists of a comprehensive analysis of the quantitative data as well as summarized theme categories of the qualitative data.

The researcher made use of a comprehensive literature study regarding the DSM system, as well as the role of social workers in the field of mental health,

as the basis for the DSM systems' training programme and training manual. The programme was evaluated in a pilot study prior to the official presentation, in order to identify any shortfalls or errors.

The researcher presented the training over two days and did a preliminary of the programme in order to refine and enhance the content to maximize the value. Seventy-nine (79) respondents attended the first day, while seventy-five (75) respondents attended the second day.

The respondents completed a questionnaire on the first day, prior to the training. The pre-test questionnaire had two sections, section A which gathered biographical data, and section B, which assessed the respondents' views, knowledge and opinions regarding the DSM system. After the two-day training, the respondents had to complete the post-test questionnaire. The post-test questionnaire also consisted of section A, which focused more on the evaluation of the training programme, while section B had similar questions as in Section B of the pre-test, in order to compare the respondents' views, knowledge and opinions regarding the DSM system, after the completion of the training. .

The biographical data from the pre-test questionnaire indicated that the respondents' main expectation of the training programme was to obtain knowledge of the DSM system and to find clarity on mental health issues. Most of the respondents worked for the government, for NGO's or in the private sector and most of them had a graduate qualification. The majority of the respondents were between the ages of 30 and 49 years and assessed 10–49 clients per month. Most of the respondents did not receive any training in the DSM system, although a significant number of respondents attended additional training or conducted self-study to learn more about this system.

The pre and post-test comparison on the respondents' views, knowledge and opinions related to the DSM system indicated that the respondents felt that they have learned and developed from this DSM programme. The respondents

felt more knowledgeable and confident after the training in their ability to assess and assist mental health patients. Respondents' overall view on the DSM system was that the system is necessary, is useful and that it may enhance the social work profession. In conclusion of this section, the respondents indicated that prior to the training, they felt that their social work assessments were occasionally regarded as valuable by other professionals, while on completion of the training, they felt that their assessments could be of more value, if they as social workers were more knowledgeable in mental health issues.

In Section A of the post-test, the evaluation of the training programme indicated that eighty-four percent (84%) of the respondents were of the opinion that the training in the DSM system is beneficial to the social work profession to assist social workers to provide comprehensive assessments. The training empowered social workers and assisted them to formulate more appropriate treatment plans. Seventy-four (98.7%) of the 75 respondents responded that the training would assist them personally in their role as a professional social worker and indicated that they would recommend the training to their colleagues.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This research report consists of six chapters. Chapter 1 focuses on the introduction of the research study and includes the problem formulation, the research goal, objectives and hypothesis. The chapter also includes the ethical aspects, definitions of some of the main concepts and concludes with the limitations within this study.

Chapter 2 is the literature study on social work in mental health within the South African context. This literature study concentrates on the role of social work in mental health with regard to the various mental health sectors, the mental health team, social work qualifications in mental health and social work methods and approaches in mental health.

Chapter 3 focuses on literature on the DSM-system and forms the basis for the content of the training programme. The chapter discusses the reason for utilizing the DSM system, and not another system, the terminology in the DSM, the history as well as the multi-axial assessment of the DSM system, and concluded with the limitations and advantages of the DSM system.

Chapter 4 addresses the research methodology and specifically the research approach, type of research and the phases of intervention research. The chapter also includes the description of the research population and sampling method.

Chapter 5 includes the results of the empirical study and discusses the research data after the DSM training programme was presented to social workers. The analysis of the quantitative data is discussed in this chapter and the qualitative data is analysed and presented in identified themes.

Chapter 6 is the summary, conclusions and recommendations of all the previous chapters as well as an evaluation of the research goal, objectives and hypothesis.

Diagram 5: Format of Chapter 6
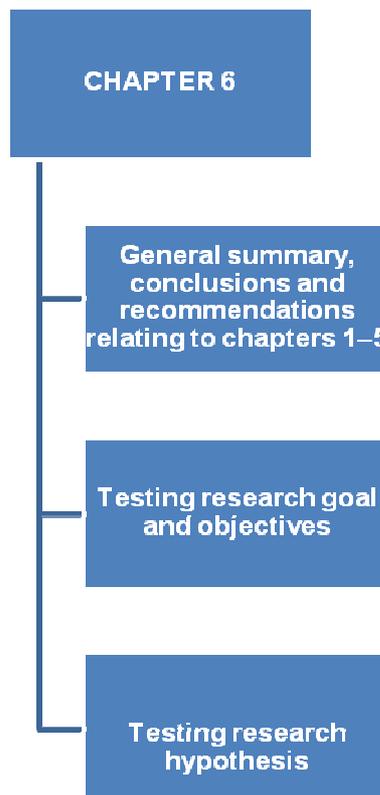
6.2 CHAPTER 1: INTRODUCTION TO STUDY

6.2.1 Summary

The content of the chapter includes the current utilization of the DSM system by social workers and highlights various views from professionals involved in mental health in South Africa. It became clear from the discussion that social workers in South Africa often use the DSM system without training. The research problem was formulated based on social workers stating that they use the DSM system, regardless of their training or lack of training in the DSM system. Social workers do not always receive sufficient training in mental health diagnostic systems while receiving their formal education.

The goal for this study was to develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system, namely the DSM system, when dealing with individuals who present with a specific disorder.

The hypothesis that directed this research indicated that if social workers receive formal training in the utilization of the DSM system, it will equip them with knowledge and insight with regard to the mental health of their clients. This will enhance the profession, since social workers will be able to participate in the multi-professional team with insight with regard to mental health terminology and pathology.

The researcher addressed various ethical aspects such as the avoidance of harm, obtaining informed consent, ensuring cooperation with contributors, avoiding any deception of the respondents, ensuring competence from the researcher's side and focused on the privacy, confidentiality and anonymity of the respondents.

Some of the identified limitations of this study were the lack of research on the utilization of the DSM system in South Africa, the need for training over a longer period, the uncertainties regarding the practical definition of 'clinical social work' and the need for a nationally accepted scope of practice for social workers.

6.2.2 Conclusions

The following conclusions are made based on the introduction of this study:

- Mental disorders affect the lives of millions of people. Social workers have to address their clients' problematic situations holistically, which may lead to social workers using the DSM system without any training. The mere fact that social workers utilize the system, regardless of training in this field

or the lack of training, is a clear indication that training in this field is necessary in the social work profession.

- The lack of a clear scope of practice for social workers in South Africa, and with that their right to do mental health diagnoses or even work with mental health clients, has led to conflict. It seems that there is not yet a clear agreement between the role players within South Africa, such as the South African Council for Social Service Professions (SACSSP) and the South African Association of Social Workers in Private Practice (SAASWIPP).

- One of the main concepts, namely 'clinical social work', is well defined in international literature. However, very little literature was found within the South African context pertaining to who is qualified to be a clinical social worker. It seems that there is controversy since only a limited number of academic institutions provide a postgraduate qualification in this field, and would rather refer to their specialized mental health postgraduate degree in other terms. This has caused some conflict on a practical level among social workers and 'clinical' social workers when operating in the field of mental health since the perception exists that some social workers overstep their boundaries or scope of practice.

6.2.3   Recommendations

- A training programme in the DSM system should be made available to social workers since it is not only a need but also a necessity for work in the mental health field.

- The South African Council for Social Service Professions, which is a legal entity, needs to clarify and confirm the scope of practice for social workers.

- The growing confusion regarding 'clinical social work' needs to be addressed within the South African context. A generic field of training for

the mental health component as part of the learning programmes for social workers might address the current conflict.

6.3 CHAPTER 2: SOCIAL WORK IN MENTAL HEALTH

6.3.1 Summary

The dearth of resources regarding the use of the DSM system in practice highlights the necessity for more attention and research in this area, since knowledge of the disorders, as defined in the DSM system, can benefit the profession. Social workers are expected to use the DSM system although they have often not received any official training in this field. The researcher is concerned that social workers without specific training in the DSM system will have limited knowledge, although they are expected to know of and utilize this system.

Social workers have universal aims, which are to assist their clients, or patients with practical solutions for their problems, improving their social functioning, give hope, provide guidance so that they can take responsibility for their own problems, and support the vulnerable. Ironically the approach for mental health patients are also universal with similar aims as the social work profession, and social workers will therefore come across mental health affected clients or patients. Social workers should therefore be knowledgeable in the field of mental illness.

Currently social workers are working in various mental health settings such as community mental health centre's, general hospitals, psychiatric hospitals, emergency and crises intervention services, employee assistance programmes and within private practice.

There is little doubt that the quality of mental health social work has vastly improved over the years, and that the role social workers could play in the field of mental health could increase. The development of adequately operationalized and empirically tested contextual systems of assessment

remains a principal challenge for contemporary social work. The value and benefit of intensive group training in the DSM system for social workers in South Africa needs to be assessed and researched since no data is presently available in the local context to validate social workers' use of the DSM.

6.3.2 Conclusions

The following conclusions are drawn from the literature study on social workers in mental health:

- An increasing number of social workers in South Africa deal with a client load where various mental health disorders could be present or even be a trigger for the clients' own problematic responses to their social or economic problems.

- Social workers have a definite role to play in mental health since mental health disorders include not only the psychological and physical context, but also the social and emotional context, in which the social worker is the specialist.

- There are still uncertainties within the South African context pertaining to the social workers' scope of practice when dealing with mental health patients.

- Social workers are accepted as mental health practitioners and as part of the mental health team. It is therefore significantly important that social workers understand mental health disorders and will benefit from understanding and utilizing a system such as the DSM system.

- Social workers receive very little and often no training in mental health related tools, diagnoses and theories, which is a shortfall since this profession often forms part of a mental health team.

- Basic knowledge and application of the DSM system can be a tool in the creation of a diagnostic impression in social work that will enable the social worker to participate in the consultation process with other professionals.

6.3.3   Recommendations

- The lack of a formalized and accessible social work scope of practice needs to be addressed on government level with input from various bodies, such as the South African Association of Social Workers in Private Practice (SAASWIPP).

- The academic curriculum for social work programmes in South Africa should include more training in the field of mental health, in order to equip social workers to fulfil their role as a mental health practitioner and team member.

- Social work training should equip the social workers with skills and knowledge on assessing and recognizing mental health disorders in order to make the correct referrals for the appropriate illnesses.

6.4 CHAPTER 3: DSM SYSTEM

6.4.1   Summary

There are various arguments as to why social workers should or should not make use of the DSM. Social workers are ambivalent towards classification systems for clients and have concerns about the degree to which categorizing and labelling clients as delinquent, unemployable, schizophrenic or mentally retarded increases stigma, shape expectations and limit opportunities.

Knowledge of diagnostic criteria can assist the social worker to address the overall functioning level of their clients. Clients and their family members may have limited information about mental health issues. The well-informed social

worker may be able to assist with correcting wrong ideas and perceptions, formulate a treatment plan and make referrals to the professional treatment team.

The DSM can provide a layperson with information to refer people who may have a mental disorder to psychiatric counselling or treatment. The DSM does not provide information about treatment or the cause of a mental health problem.

6.4.2 Conclusions

The following conclusions are drawn from the literature study on the DSM system:

- Since the field of mental health involves anything from divorce adjustment services and treatment of substance abuse to the treatment of depression and schizophrenia, it is important that social workers should understand and be familiar with a mental health diagnostic system, such as the DSM system which is the most commonly used system worldwide.

- Many people have signs or symptoms of mental health disorders that neither they nor others consider an indication of a mental disorder, and again some people present completely 'normal' and do not show any evidence of signs or symptoms pertaining to mental health disorders that might be present.

- The DSM is globally the most used mental health diagnostic system since the first edition was published in 1952, followed by revisions and subsequent editions.

- The inclusion of the Multi-Axial Assessment, more specifically Axis IV, does not only provide resolutions for some of the criticisms of the DSM

system, but also highlights the role of social work in dealing with mental health clients.

- Social workers, who are equipped with a basic knowledge and training in the use and even the misuse of the DSM system, will be in a much better position to understand and refer to the diagnostic criteria. Basic knowledge and training in the DSM can assist the social worker to enhance the overall functioning levels of their clients.

- Well-informed social workers can correct distortions and foster cooperation and referrals in the treatment plan among the mental health treatment team professions.

6.4.3 Recommendations

- Social workers should not only be educated in a mental health diagnostic system, but should also understand the terminology used in mental health, such as mental health illness, disorders and psychosis.

- Training in the DSM system should provide adequate training in the multi-axial system, Axis IV (Psychosocial and environmental problems), since that is the social workers' field of speciality.

6.5 CHAPTER 4: RESEARCH METHODOLOGY

6.5.1 Summary

The goal of this research study was to develop, implement and pilot test a programme to train social workers in the utilization of an accredited diagnostic system namely the DSM system.

The research objectives were: completing a literature study regarding social workers' diagnostic and assessment tools and techniques; exploring social

workers' knowledge, attitude, and utilization of the DSM system; developing a training programme in the utilization of the DSM system for social workers; measuring the effectiveness and utilization of the content of the training programme; and making conclusions and recommendations regarding the benefit of a training programme for social workers in the DSM system.

A combined quantitative/qualitative approach, with the embedded mixed method design was followed. The researcher chose the embedded mixed method since the primary method was a quantitative approach, supported by a qualitative approach as secondary method.

This research was applied intervention research since the aim of the entire study was to contribute towards the practical issue, namely, to put in place training for social workers who use the DSM system without training and social workers who have a need to be more knowledgeable regarding the DSM system. This training programme in the DSM system is an attempt to an implemented and pilot tested intervention to address these practical issues amongst practitioners.

The data collection was done while the respondents attended a two-day training programme in the DSM system. Prior to the commencement of the training, the respondents had to complete a pre-test questionnaire in order to assess their views regarding mental health and the DSM system. After two days, on completion of the training programme, the respondents had to complete a post-test questionnaire to assess their views after the training. The data analysis was based on a pre-experimental design, namely the 'one-group pretest-posttest design' that contributed to making valuable interpretations and comparisons regarding the impact and value of the training programme.

The research methodology was based on the six phases of the intervention research process. In the first phase, the researcher identified the research problem, namely social workers often using the DSM system, without training, and the identified need amongst social workers for more knowledge regarding mental health. This phase also focused on the project planning, where the

researcher not only identified and involved social workers, but also received cooperation from the social work departments of the South African Police Service and the Department of Correctional Services, as well as various private institutions.

The second phase of the intervention research process focused on the gathering of information. Very little social work literature exists regarding this field of study, especially within the South African context. Experts in the field, such as social work academics, social workers in private practice, clinical social workers, clinical psychologists and psychiatrists were approached for their expert view and guidance regarding this subject.

Within the third phase, the researcher addressed the quasi-experimental design, namely the one-group pretest-posttest design. The researcher developed a training programme in the DSM system for social workers. The programme and the data collection methods, namely the questionnaires, were tested in the fourth phase. The research problem and questionnaires were pilot tested with various experts in the field to ascertain the adequacy, quality, and practicalities of the training programme.

The fourth phase of the intervention research process focused on the pilot testing the training programme, whereby the researcher collected data pertaining to biographical information, the DSM system and the DSM training programme, as well as data pertaining to social workers' assessments.

The last two phases of evaluation and advanced development as well as the dissemination of the programme could be addressed in future research. There is a need for a training programme on the DSM system as the researcher received requests from various companies to provide the training and manual, and the request that the training should be registered for continuous professional development (CPD) points due to the value that it could add to their work environment.

The research population was social workers working with a client base in South Africa, while the sample consisted of 79 social workers from the Western Cape. The sample of social workers was purposively chosen from social workers working with clients specifically in the Western Cape area.

6.5.2 Conclusions

The following conclusions are drawn from the research methodology:

- This study had an applied research goal since the research aimed to attend to a specific problem in practice, namely developing, implementing and evaluating a programme to train social workers in the utilization of an accredited diagnostic system, namely the DSM system. In this study, the applied research worked well since the results can be implemented in practice.

- The first four phases of the intervention research process was applicable, since this study aimed to develop, implement and pilot test a new training course for social workers in the DSM system.

- The research consisted of four phases, the first phase of which was the problem analysis and project planning. This phase concluded that social workers actually seek training and assistance in using diagnostic systems since they are using the DSM system, regardless of the lack of training.

- The second phase that focused on information gathering concluded that more research in this field is needed since no previous research was available within the South African context.

- The pilot study was the fourth phase; this phase concluded that the content and evaluation measurements of the training programme were indeed adequate and that the study was feasible. In pilot testing the training programme, quantitative and qualitative data was collected with a

pre-test and post-test questionnaire that enabled the researcher to capture and process the data electronically.

- The fifth phase of evaluation and advanced development can be addressed in future research. The researcher received requests for more training in the DSM system, indicating the need for such a training programme.

6.5.3   Recommendations

- Since there is no existing South African research with reference to social workers using mental health diagnostic tools, it is recommended that more research should take place within the South African context on themes such as:
    - social workers' ability to intervene with mental health patients;
    - clarity on the scope of practice for social workers;
    - clarity on the various speciality fields in the social work profession;
    - identifying and/or developing other social work interventions for mental health patients.

- Future research could focus on Programme Evaluation in order to improve the training programme, as developed for this study.

- A training programme in the DSM system should rather be presented in the format of a certain number of modules over a set period, whereby social workers could have adequate time to familiarize themselves with all the terms, references and categories of mental health disorders and have the opportunity to integrate the new knowledge in practical examples.

- This training programme could be presented to social workers as a continuous professional development (CPD) training opportunity, as part of the dissemination planning.

6.6 CHAPTER 5: EMPIRICAL STUDY, DATA ANALYSIS AND INTERPRETATION

6.6.1 Summary

This chapter represents all the empirical data as obtained from the study and consists of a comprehensive reflection of the quantitative and qualitative data.

The researcher made use of a comprehensive literature study regarding the DSM system as well as the role of social workers in the field of mental health, as the basis for the DSM system training programme and training manual. The programme was presented as a pilot study prior to the official presentation, in order to identify any shortfalls or errors.

The researcher presented the training over two days and evaluated the programme in order to refine and enhance the content to maximize the value. Seventy-nine (79) respondents attended the first day of the training programme, while seventy-five (75) respondents attended the second day.

Respondents completed a questionnaire prior to the training. The pre-test questionnaire had two sections: section A gathered biographical data, and section B, which assessed the respondents' views regarding the DSM system.

After the two-day training, the respondents had to complete the post-test questionnaire. The post-test questionnaire also consisted of a section A, which focused more on the evaluation of the training programme, while section B had similar questions as the pre-test questionnaires' Section B, in order to compare the respondents' views, knowledge and opinions regarding the DSM system, after they had completed the training.

The biographical data from the pre-test questionnaire indicated that the respondents' main expectation of the training programme was to obtain knowledge of the DSM system and to find clarity on mental health issues. Most of the respondents either worked for the government or for NGOs or in

the private sector and most of them had a graduate qualification. The majority of the respondents were between the ages of 30 and 49 years and assessed 10–49 clients per month. Although many respondents never received any formal training in the DSM system, a relatively high number of respondents attended additional training or conducted self-study to learn more about this system.

The pre-test and post-test comparison on the empirical data for the respondents' views, knowledge and opinions related to the DSM system indicated that the respondents felt that they have learned and personally developed from the DSM programme. After the training, the respondents felt more knowledgeable and competent to assess and assist mental health patients. The respondents' overall view on the DSM system was that the system is needed, is useful and that it will enhance the social work profession. In conclusion of this section, the respondents indicated that, prior to the training, they were of the opinion that their social work assessments were only occasionally regarded as valuable by other professionals, while on completion of the training, they felt that their assessments could be of more value, because they were more knowledgeable about the DSM system.

The post-test questionnaire's section A, the evaluation of the training programme, indicated that sixty five (65) (84.4%) of the respondents felt that the training in the DSM system is beneficial to the social work profession, since it assists social workers to provide more comprehensive assessments, it upgrades and empowers social workers and assists them to formulate more appropriate treatment plans. Seventy-four (74) (97.3%) of the respondents admitted that the training would assist them personally in their roles as professional social workers and a further 74 (98.7%) indicated that they would recommend the training to their colleagues.

6.6.2 Conclusions

The following conclusions are drawn from the empirical study, data analysis and interpretations:

- Social workers have a need to know more about the DSM system and to have clarity on mental health issues.

- Social workers receive very little training in mental health as part of their undergraduate training and that explains the significant need for more training in this area, since social workers have to work in mental health settings and with mental health patients, regardless of their training.

- The training in the DSM system increased social workers' perception to consider the use of well-researched diagnostic criteria in their dealings with mental health care users and in communicating with other members of the multidisciplinary team.

- It would appear that although the social workers became more hesitant about doing psychotherapy themselves, the training allowed them to consider other options, viz. to use other therapeutic interventions, to deal with the client holistically and to refer mental health problems to other members of the multidisciplinary team.

- The use of the DSM system would enhance the social work profession since social workers felt that they would be able to communicate more professionally with their colleagues in order to maintain a position as a respected member of the multi-disciplinary treatment team.

- Almost all the respondents stated that they attended the training due to a personal interest and a need to know more, which clearly indicated the need for training in this field. The large number of respondents that already trained themselves through either additional courses or self-study supported this statement.

- Training may enhance the professionalism of social workers amongst other professionals, and knowledge of the DSM criteria can assist the social worker to address their clients' overall level of functioning.

- Social workers are eager to improve their knowledge and skills. Social workers should be keenly aware and alert to updates in diagnostic criteria throughout the intervention. This training in a diagnostic tool would equip the social work professionals to provide better client services and provide an opportunity for the profession to recognize malpractice in terms of the DSM system.

- The DSM system may enhance the social work profession since social workers will be able to communicate with their colleagues in order to maintain a position as a respected member of the multi-disciplinary treatment team.

6.6.3 Recommendations

- Training in a diagnostic system is significantly important since social workers highlighted their need and interest in this field; 63% of the attendees further responded that they have never received any training in the DSM system, while 37% received training either at their academic facility or through additional courses and self-study.

- A similar training curriculum as part of undergraduate education should be considered since there is a rapid growth of social work practice, and more specifically medical social work, stimulated by the need for multi-professional collaboration in multi-disciplinary settings and for teaching allied disciplines.

- The DSM training programme will have to include practical examples and case studies of various factors such as:
  o formulating a treatment plan,
  o referral methods, and
  o maintenance of a position as a respected member of the multi-disciplinary treatment team.

- Seventeen (22%) respondents recommended the inclusion of more case studies or examples when referring to the disorders and Axis levels.

- More opportunities should be provided to practically implement some of the information provided.

- Many social workers recommended follow-up training since it was of great value.

- Social workers should be made aware of, and receive additional training where necessary to make a comprehensive assessment based on the health care approach consisting of three cycles that will dictate the presenting symptoms of an individual, namely the physical, the psychological and the socio-economic contexts. Social workers should be aware of the importance of the entire context in order to make a more comprehensive assessment.

6.7 EVALUATION OF GOAL AND OBJECTIVES OF STUDY

6.7.1 Goal

The goal of this study was **to develop, implement and pilot test** a programme to train **social workers** in the **utilization of an accredited diagnostic** system, namely the DSM system, when dealing with individuals who present with a specific disorder.

Research Outcome

The researcher achieved this goal since she:
- **developed** a programme with a 130 page manual that refers to mental health in general, social workers' role in mental health, mental health with regard to the regulating body (Department of Health) and detail with

regard to the DSM system. The last module of the programme included all the disorders as listed in the DSM, with a short overview and history on some of the disorders. The entire manual and programme relied on the information gathered for this thesis;

- **implemented** the above referred programme over a two-day training intervention in Cape Town, October 2008; and

- **evaluated** the above named programme (with manual), since the respondents had to evaluate and comment on the programme and content. The respondents had the opportunity to indicate their views with regard to the DSM system. The researcher made use of open-ended questions here, especially to get the personal evaluation of each respondent. All of the respondents were positive, with good evaluation feedback.

The researcher accepts that the evaluation of this intervention could have been more extensive. This research study therefore provides a platform for further training and intervention, as dictated by the intervention research design.

6.7.2 Objectives

6.7.2.1 Objective 1

The first formulated objective was to do a literature study regarding social workers' diagnosis and assessment within the context of the DSM system.

Research outcome:
A literature study regarding social workers' diagnosis and assessment tools and techniques was completed:

- It appears that social workers in public sectors are expected to do diagnosis and assessment, regardless of their tools, training or techniques or lack thereof, due to the lack of finances and psychiatric and clinical psychology resources.

- It appears that social workers in private sector make a definite separation between generic social work and clinical social work. Clinical social workers are making diagnoses and according to literature are allowed to diagnose mental health conditions.
- Training for social workers in mental health is overall limited, regardless of mental health diagnostic and assessment tools.

This research study indicated controversial issues pertaining to this subject, and therefore the objective is very broad and dynamic. This is an indication for more research in this regard, but that is the purpose of intervention research – to stimulate further research with intervention or programme design. The researcher is of opinion that this objective was met. Uncertainties with regard to social workers' scope of practice in mental health, leaves social workers without guidance or diagnostic and assessment tools and techniques. Social workers rely on their training in direct work, with various approaches to deal with mental health clients.

6.7.2.2   Objective 2

To explore social workers' knowledge, attitude, and utilization of the DSM system.

Research outcome:
The researcher reached the second objective with regard to the following:

- **Social workers' knowledge of the DSM system:** Various South African universities agree that social workers receive little or no information in their training with regard to the DSM system, and therefore would have limited knowledge. Even social workers, who admitted to using the system, stated that they have not received any education in this regard. In the empirical data the respondents, in the context of this study the social workers, confirmed that they received limited opportunities and training to obtain knowledge about the DSM system.

- **Social workers' attitude of the DSM system:** From the literature investigation, it seems that social workers are either pro or against the use of the DSM system, with various reasons as discussed in Chapter three under limitations and advantages of the DSM system. The empirical data indicated that there was a significant change of attitude after the intervention. Respondents changed their attitude from lack of confidence to being confident that social workers will be enabled to make earlier and more appropriate referrals, will make assessments that are more comprehensive, and that knowledge of the DSM system will upgrade and empower the social work profession and assist social workers to find the appropriate treatment plan.

- **Social workers' utilization of the DSM system:** The literature study indicated that there are controversial views to the right of social workers to use the DSM system. The researcher found from interviews with various experts and from her own experience, that social workers utilize the DSM system. The researcher explored and found from the empirical data that there was a further significant change with regard to the utilization of the DSM prior to the intervention compared to after the training. However, this objective aimed at exploring, and is not a guarantee that the social workers will indeed utilize the system, but rather an indication that they are planning to do so.

Based on the above, the researcher believes that this objective, which is also broad, was reached. Again, there is scope for more questions and measurement tools and therefore more research in this regard. This is in line with one of the outcomes of intervention research, namely to stimulate further research with intervention or programme design.

6.7.2.3   Objective 3

To develop a training programme and train social workers in the utilization of the DSM.

Research outcome:

The researcher developed a training programme with a 130-page manual, since this was also the primary goal of the research study. The training was presented over a two-day period and the content of the manual is listed in Chapter 4, although this entire research report formed the basis for the training manual.

6.7.2.4   Objective 4

To measure the effectiveness and utilization of the content of the training programme.

Research outcome:

The empirical data indicated that the training programme was perceived as a valuable course. The respondents felt that a training programme such as this one was effective and the content can be utilized for future training. The qualitative data indicated:

- the social workers were of the opinion that training in this field could make their assessments more valuable and professional;
- that social workers could be able to make earlier and more appropriate referrals, comprehensive assessments, and that the knowledge of the DSM system will upgrade and empower the profession and assist with the appropriate treatment plan.

This concurs with the literature study that showed that such a training programme could assist social workers to understand and use the mental health language used in the DSM system.

This objective was reached; however, it could be viewed as a rather vague objective since the question could be raised as to the meaning of 'effectiveness' and 'utilization'. The researcher is of opinion that the training could either have been effective – and therefore voted for as a good functional training, or as ineffective, whereby respondents would have indicated that

they were not satisfied and that expectations were not met. In this instance, all the quantitative and qualitative data indicated an effective score according to the collected responses.

To measure utilization in this regard is impossible, since the post-test took place immediately after the intervention, and intended utilization were measured. This measurement indicated that the respondents intended to utilize this system. Further research with regard to on-going research and interventions could be of value.

6.7.2.5 Objective 5

To draw conclusions and make recommendations with regard to the benefit for the social work profession as well as to multi-professional teamwork, should social workers receive training in the DSM system.

The researcher is of the opinion that she achieved the last objective within the scope of developing and pilot testing the DSM training programme. Conclusions and recommendations were made according to the literature study as well as the empirical study. These recommendations concur with the applied research aim to improve practical situations or problems.

6.8 TESTING RESEARCH QUESTIONS AND HYPOTHESIS

6.8.1 Research questions

All the research questions were answered.

- Are social workers qualified to do mental health diagnosis?
  - o There are international uncertainties to whether a generically trained social worker is qualified to do mental health intervention or not. Some authors and experts accept diagnosing as part of social work, while some do not accept it. Universities are clear that social workers' training is limited with regard to mental health and especially diagnosis.

- Are social worker's already working with diagnostic tools?
  - o The researcher found from the literature, experts and empirical data that social workers are doing mental health assessments, and that some authors even noted that social workers could diagnose. However, it seems that training and education with regard to mental health and mental health assessments are limited.

- What is the scope of practice for mental health social workers?
  - o The researcher found a major problematic area to be the shortfall of a mental health social work scope of practice for South African social workers. The concern that social workers assess and even diagnose in the field of mental health, without adequate training, was raised in the literature study, discussions with experts and was noted by respondents.

6.8.2 Research hypothesis

The research hypothesis is as follows: If social workers receive formal training in the utilization of the DSM system, it will equip them with knowledge and insight with regard to the mental health of their clients. This will enhance the profession, since social workers will be able to participate in the multi-professional team with insight with regard to mental health terminology and pathology.

The researcher found the following with regard to the development of a hypothesis (**an answer** to a **problem** that was **empirically tested**):

Problem:
- Currently in South Africa, social work as a profession is not fully accepted in the private health sector, and as part of the mental health team. This may be due to uncertainties and lack of a scope of practice in social work in mental health.

- Social workers are often not familiar with the mental health terminology since this may not have been part of their initial undergraduate training.

- A scope of practice will guide social workers with regard to their mental health assessments and treatment, but in the absence thereof, social workers have to rely on their generic skills and training to do so.

- Social workers are forced by agencies and the public sector to use the DSM system, or to comment on the criteria, and without adequate education and knowledge, the social workers would not be able to make a relevant professional input, as expected from other mental health practitioners.

- There are uncertainties in the mental health profession not only amongst social workers (clinical vs. generic social workers) but also with other professions, with regard to the quality and role of social services in mental health.

Answer:

- The researcher could not find any formal (historic or current) training in South Africa on the utilization of the DSM system, particularly for social workers, and therefore initiated such a training (intervention). Especially with the absence of formal training at university level, the researcher felt that formal training could provide a platform for social workers to become familiar with, obtain knowledge and insight with regard to the mental health of their clients.

- This could assist in enhancing the social work profession since social workers will have insight into the mental health terminology and pathology.

Empirical study:

- The need for formal training in the DSM system (to enhance the profession with knowledge and enable social workers to participate in the multi-professional team) was supported by not only the literature study, but also the empirical study.

- The majority of the respondents indicated that training which provides knowledge and insight with regard to the DSM system could benefit social workers, and therefore enhance the profession.

- There was a significant increase after the training whereby 98.7% of the respondents were of the opinion that they would make use of the DSM system.

The researcher therefore believes that this hypothesis was empirically tested. It could be argued that more instruments should be used to measure 'knowledge and insight with regard to mental health'. The researcher is of opinion that due to the lack of previous research, it has been difficult to narrow aims, objectives and the hypothesis, prior to the study. However, the study has indicated that there is a definite need for further research in this field.

6.9 CLOSURE

Depression, suicide, violence, and abuse are no longer hidden concerns. These are just a few examples of mental health issues that social workers have to deal with on a daily basis. This study has indicated that mental health behaviour consists of psychological, physical and psychosocial facets. However, it was found that social workers receive very little training in mental health diagnoses and criteria, regardless of the practical need. This study has developed a training programme in the DSM system and after the implementation of this two-day training programme, social workers indicated in their evaluation a need for more and regular training in this field. The researcher evaluated the programme through a pre-test and post-test. The preliminary evaluation indicated that the programme was successful in contributing to social workers' knowledge of the DSM system when dealing with individuals who present with a specific disorder.

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APPENDICES

Appendix 1: Letter of informed consent

11 March 2008

INFORMED CONSENT

1.   NAME OF RESEARCHER: Catharina Johanna Olckers
204 Cisiticola Street
Zambezi Country Estate
Zambezi Road
Montana Gardens

Cell: 082 773 1379

2.   NAME OF INSTITUTION
Department of Social Work and Criminology
University of Pretoria
Pretoria
0002
Contact person:
Dr C.E. Prinsloo
Tel: 012-4202601

3.   RESEARCH TITLE
A training programme in the DSM system for social workers.

4.   PURPOSE OF THE RESEARCH STUDY
The purpose of the doctoral research is to develop, implement and evaluate an intervention that trains social workers in the utilization of the DSM system, when dealing with individuals who present with a specific disorder.

5. ACTIVITIES INVOLVED IN THE RESEARCH STUDY

The research activities include focus group interviews and gathering information through a questionnaire. The focus group interviews will be approximately two hours long.

6. RISKS INVOLVED IN THE RESEARCH STUDY

The focus group interviews will be conducted in a safe secure environment. Any information provided for the focus group interviews and the questionnaire will be treated in strict confidence. I will not be required to furnish my personal particulars.

7. BENEFITS OF THE RESEARCH STUDY

I will benefit from the research study by undergoing training in the DSM system to use in mental health intervention. The recommendations of the research will inform academic institutions whether formal training in the DSM system as part of the social work curriculum could be of any value.

8. RIGHTS OF THE PARTICIPANTS

My participation in the research is on a voluntary basis. I may, if I wish to, withdraw at any time that I prefer. Upon my withdrawal, the information I provided for the research will be destroyed.

9. CONFIDENTIALITY

All information gathered for the research will be treated in strict confidence. The only person who will have access to the information will be the researcher. The research data will be stored for ten years in a secure place to ensure the confidentiality of information and for future research purposes.

10. AGREEMENT TO PARTICIPATE IN THE RESEARCH STUDY

This document was signed at _____ on the _____day of _____ 2008.

SIGNATURE OF RESPONDENT:

…………………………………………………….

SIGNATURE OF RESEARCHER:

……………………………………………………………………………………

MRS K OLCKERS

Appendix 2: Pre-test questionnaire

PRE-TEST QUESTIONNAIRE
SECTION A

1   Respondent number   V1

2   What do you hope to learn at this training

    _____

    _____   V2

    _____

3   Please indicate which sector/s you work in (maximum of **2** sectors)

Private	1
Government	2
Academic	3
Industry	4
Other (specify)	

V3
V4

4   Qualification in Social Work

Graduated in SW	1
Masters Degree in SW	2
PhD in SW	3
Other:	

V5

5   Highest Degree obtained at

Stellenbosh University	1
Western Cape University	2
University of Cape Town	3
University of Pretoria	4
University of Johannesburg	5
University of Freestate	6
Other	

V6

6   Year Qualified   19 ☐☐   V7
                            20 ☐☐

7   Age in years   ☐☐   V8

8   How many clients do you assess monthly?

                          ☐☐   V9

9   Approximately how many patients present(s) with mental health issues monthly?

                          ☐☐   V10

10 Why are you attending this training (maximum of **2** reasons)?

V11
V12

Personal interest	1
Obligated to attend	2
Have a need to know more	3
Have no idea	4
Other	

For office use only

PRE-TEST QUESTIONNAIRE [ ][ ][ ] (Respondent no.)

11   Did you receive any training in the DSM system?

	Yes	No	
Under graduate	1	2	V13
Post graduate	1	2	V14
Additional courses	1	2	V15
Self study	1	2	V16
Other			V17

12   Do you make use of an alternative diagnostic tool?

No	1	V18
Yes	2	V19
If yes, please name the tool:		

SECTION B

13   Do you make use of the DSM-IV?

Never	1	V20
Seldom	2	
From time to time	3	
Most of the time	4	
Always	5	

14   How do you manage clients presenting with mental health issues?

	Yes	No	
Do psychotherapy	1	2	V21
Use other therapeutic interventions	1	2	V22
Work only with social issues	1	2	V23
Refer to GP	1	2	V24
Refer to Psychiatrist	1	2	V25
Refer to Psychologist	1	2	V26
Other			

15   Do you feel you have enough knowledge to identify mental health issues?

Never	1	V27
Seldom	2	
From time to time	3	
Most of the time	4	
Always	5	

16   Please select one only: DSM-IV stands for

Diagnostic Social Manual of Mental Disorders, 4th Edition	1	V28
Dealing with Social and Mental Disorders, 4th Edition	2	
Diagnostic and Statically Manual of Mental Disorders, 4th Edition	3	
Dealing with Statistical Mental Disorders, 4th Edition	4	
I do not know	5	

For office use only

PRE-TEST QUESTIONNAIRE ☐☐☐ (Respondent no.)

226

17 Do you have a need for training in mental health with regard to:

	Yes	No
Mental Health Assessments	1	2
Mental Health Care	1	2
Mental Health Treatment	1	2
Mental Health Disorders	1	2
Other	1	2

V29 ☐
V30 ☐
V31 ☐
V32 ☐
V33 ☐

18 What is your view on social workers using a diagnostic tools
(select a maximum of 3)

I have no opinion	1
It is needed	2
It is dangerous	3
It is useful	4
It will reflect negatively on the profession	5
It will enhance the profession	6

V34 ☐
V35 ☐
V36 ☐

19 In your view, do other professionals value assessments made by social workers?

Never	
Seldom	
Time to time	
Most of the time	
Always	

V37 ☐

Appendix 3: Post-test questionnaire

POST-TEST QUESTIONNAIRE
SECTION A

1 Respondent number

V1

2 In your view, would training in the DSM system assist social workers in conducting more professional assessments?

No	1
Yes, but only with limited cases	2
Yes, with all assessments	3

V2

3 Give three reasons:

a) _____

b) _____

c) _____

V3

V4

V5

4 Will the fact that you have attended this course assist you in your profession as a social worker - please otivate:

a) _____

b) _____

c) _____

d) _____

V6

V7

V8

V9

5 Would you recommend this programme to your colleagues?

Yes	1
No	2

V10

V11

6 Recommendations with regard to the course content:

a) _____

b) _____

c) _____

V12

V13

V14

7 Please indicate other areas for training in mental health?

a) _____

b) _____

c) _____

V15

V16

V17

8 Remarks

a) _____

b) _____

V18

V19

POST-TEST QUESTIONNAIRE [ ] [ ] [ ] (Respondent no.)
SECTION B

9 Would you make use of the DSM-IV

Never	1
Seldom	2
From time to time	3
Most of the time	4
Always	5

V20 [ ]

10 How do you manage clients presenting with mental health issues?

Do psychotherapy	1	2
Use other therapeutic interventions	1	2
Work only with social issues	1	2
Refer to GP	1	2
Refer to Psychiatrist	1	2
Refer to Psychologist	1	2
Other		

V21 [ ]
V22 [ ]
V23 [ ]
V24 [ ]
V25 [ ]
V26 [ ]

11 Do you feel you have enough knowledge to identify mental health issues?

Never	1
Seldom	2
From time to time	3
Most of the time	4
Always	5

V27 [ ]

12 Please select one: DSM-IV stands for

Diagnostic Social Manual of Mental Disorders, 4th Edition	1
Dealing with Social and Mental Disorders, 4th Edition	2
Diagnostic and Statically Manual of Mental Disorders, 4th Edition	3
Dealing with Statistical Mental Disorders, 4th Edition	4
In do not know	5

V28 [ ]

13 Do you have a need for training in mental health with regard to:

	Yes	No
Mental Health Assessments	1	2
Mental Health Care	1	2
Mental Health Treatment	1	2
Mental Health Disorders	1	2
Other		

V29 [ ]
V30 [ ]
V31 [ ]
V32 [ ]
V33 [ ]

14 What is your view on social workers using a diagnostic tools
(select a maximum of 3)

I have no opinion		1
It is needed		2
It is dangerous		3
It is useful		4
It will reflect negatively on the profession		5
It will enhance the profession		6

V34 [ ]
V35 [ ]
V36 [ ]

POST-TEST QUESTIONNAIRE ☐☐☐ (Respondent no.)

15. In your view, would other professionals value assessments made by social workers more, if we social workers are more knowledgeable in mental health?

Never	1
Seldom	2
Time to time	3
Most of the time	4
Always	5

V37 ☐

Appendix 4

8 September 2008

Dear Social Worker

Invitation to a Free Training programme for Social Work in the Diagnostic and Statistical Manual of mental Disorders (DSM) system

---

I am currently doing a DPhil Social Work degree, through the University of Pretoria. The research topic is as follow:

A TRAINING PROGRAMME IN THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM) SYSTEM FOR SOCIAL WORKERS

So often, the public and professionals will make statements and diagnoses – formally and informally – regarding the mental health of another individual. Nevertheless, what is the basis for or system of such a diagnosis? Are social work professionals also guilty of diagnosing while assessing without using valid criteria? Is there any value in utilising one internal assessment and diagnostic system or will each clinician use a system most applicable to their practice? These are all questions raised by the researcher in a search for answers.

I have found that it is expected of Social Workers to utilize the Diagnostic Statistical Manual of Mental Disorders (DSM) system (within South Africa and the United Kingdom), regardless of social workers knowledge or lack thereof with respect to this diagnostic system.

The DSM is the standard classification of mental disorders used by mental health professionals internationally. In a self-study by myself, I have found that social workers often utilize the DSM without formal training in the system.

Based on this experience I initiate this study with the <u>aim</u> to develop, implement and evaluate an intervention that trains social workers in the utilization of the DSM system.

The two day training will focus on the link between social workers and mental health interventions, mental health assessments and the criteria's for mental health disorders. The training programme will also address methods to deal with mental health clients and focus on the role that the DSM could play as an assessment tool.

The training session will take place over two days and there is no cost involved. Training material will be distributed. Due to high volumes of confirmations, the venue will change. I will forward the details of the new venue, closer to the training date. Attached you will find the registration form and programme.

I herewith kindly invite you to this training session.

Kind regards

Karen Olckers
PhD Student
Group Operations Manager for Life Path Health
Cell: 082 773 1379
karen@lifepathgroup.co.za

CLARO CLINIC
N1 Stad
021 595 8500

Tijger Clinic
Loevenstein
021 913 7142

CLARO CLINIC
Addiction Treatment
N1 Stad
021 595 8522

P·I·N·E·S
KLINIEK
Worcester
023 342 3113

Sereno Clinic
"to make calm"
Paarl
021 872 9760
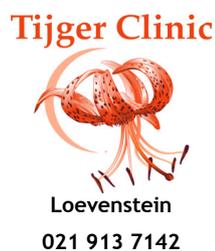
Invitation to a Free Training programme for Social Work in the Diagnostic and Statical Manual of mental Disorders (DSM) system

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Tuesday, 7 October 2008

08:00   Tea/Coffee

08:30   Introduction

09:00   Pre-training assessment

09:00   Module 1: Mental health interventions

10h45   Tea

11h00   Module 2: The link between social work and mental health interventions

12:30   Lunch

12:45   Module 3: Social work in mental health – assessments, tools

14h15   Tea

14h30   Module 4: DSM: Introduction, history & use of the DSM

16:00   Closure

Wednesday, 8 October 2008

08:00   Tea/Coffee

08:30   Review & Overview

09:00   Module 5: Multiaxial Assessment & Global Assessment of Functioning Scale

10h45   Tea

11h00   Module 6: DSM-IV-RE Classification

12:30   Lunch

12:45   Module 6: Continue

14h15   Tea

14h30   Module 7: Practical implimentation

15h20   Post Assessment Questionaire

16:00   Closure

Registration closes on Friday, 26 September 2008

Registration and Bookings
The training is free of charge, but booking is essential due to a limited number of
seats.

Enquiries
Telephonic enquiries Karen Olckers 082 773 1379
Email enquiries karen@lifepathgroup.co.za

Venue
Tijger Clinic – Training Facility
267 Hendrik Verwoerd Drive
Loevenstein
Bellville
Cape Town

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- -

Registration form

Complete all your details.

Full name(s) _____

Calling name _____

Surname _____

Employer_____

Telephone area code_____

Telephone number_____

Cellular number_____

Statutory registration number_____

Please complete and send this registration form via
Fax: **(013) 6970327 or**
E-mail **karen@lifepathgroup.co.za**
by 26 September 2008.