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

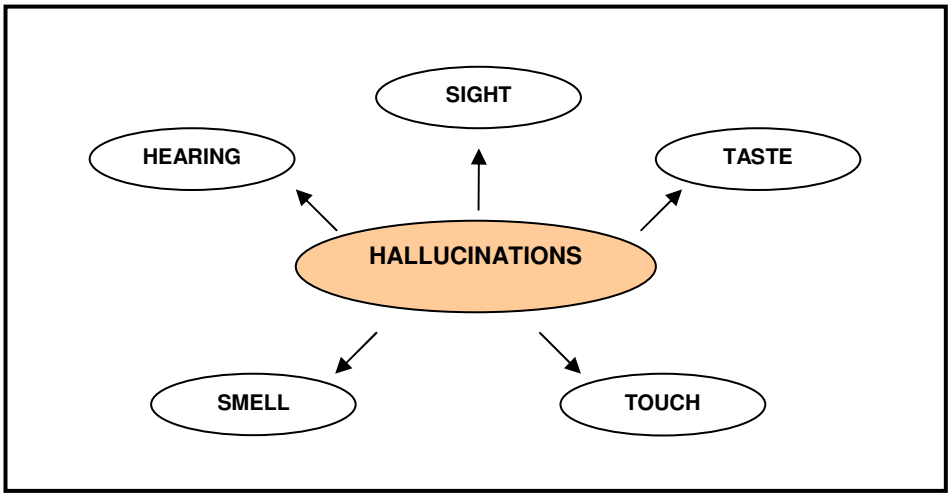
3.3.4.4 Hallucinations

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.