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Clinical Social Worker's Perception of the Impact of Revisions of the DSM-5

By

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
St. Catherine University and the University of St. Thomas
St. Paul, Minnesota
In Partial fulfillment of the Requirements for the Degree of
Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The Diagnostic and Statistical Manual is often considered the “Bible” of mental health diagnostics and is used extensively by mental health professionals in defining mental disorders. The DSM-5 was recently released on May 19, 2013. There has been much controversy and debate surrounding the release. The most dramatic is the structural change with the elimination of the multi-axes. This research examined the impact of the changes on the assessment and treatment planning process done by clinical social workers. Interviews were conducted with licensed clinical social workers employed in outpatient mental health settings to determine the impact on the patients they serve. There were major findings from this study. Consensus among clinicians interviewed was that the DSM-5 has strong ramifications for the following: (1) functions of DSM (2) stigma, (3) subjectivity of functional rating, (4) lack of guidance towards clinical interventions and (5) reclassification. The findings indicated that all participants in the study agreed that the DSM was useful for the purposes of educating individuals about their condition and giving all mental health professionals a common language with which to discuss mental health diagnoses. However, they felt the DSM is lacking in its utility for clinicians in that it does little to help determine probable causes of disorders and offers no suitable interventions to reduce or eliminate the presenting problem.

Acknowledgements

I would like to dedicate this paper to my mother who passed away shortly after I started Graduate School. My mother was always my biggest cheerleader and inspired me to follow my dreams. To my husband, Don I cannot express in words how much your enduring support and willingness to make sacrifices has meant to me on this journey. I would also like to thank my committee members: Molly Kellor and Michelle Thompson. I am so grateful for all the time and effort you have given me throughout this year. I also want to thank the chair of my research committee, Dr. Rajean Moone for his guidance through the research process.

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INTRODUCTION

The Diagnostic and Statistical Manual (DSM) is used throughout the world in clinical and research contexts. The American Psychiatric Association released the DSM-5 manual on May 19th of this year. It has been 19 years since the publication of the DSM IV. Each new revision of the DSM has seen an increase in the number, type and complexity of mental health diagnoses. According to Ben-Zeev, Young & Corrigan (2010), this reflects improvements in symptom identification and the scientific community's advances in the understanding of mental illness.

Many of the revisions to the latest edition of the DSM will likely affect how social workers both diagnose and treat mental disorders. According to Halter, Rolin-Kenny & Grund (2013), "the DSM-5 will result in restructured assessments, reformulated diagnostic criteria, altered formulas for the reimbursement of care and therefore changes in treatment patterns and strategies" (p. 24). This is an exciting time for clinical social workers to openly discuss the nature of psychopathology and how to best conceptualize it (Wakefield 2013). There are few texts within the behavioral sciences have had the influential power of the DSM. The progression of the DSM not only reflects the evolution of the knowledge base, but is an attempt to bring this body of work in alignment with other standard diagnostic tools that are universally used to monitor and classify the number and type of diseases and health conditions. The bulk of the literature on the latest revision of the DSM suggests that a few areas in particular have created the most controversy. The most dramatic is the structural change in the DSM-5 with the elimination of the multi-axial system. According to the APA, the multi-axial system in the DSM-5 "has moved to a non-axial documentation of diagnosis with separate notations for important psychosocial and contextual factors and disabilities"

(2013 p. 16). Personality disorders are now listed as a primary or additional diagnosis as opposed to their former classification on Axis II of the multiaxial system. Wakefield (2013) proposes that the primary motivation for the elimination of the axes was to place greater emphasis on making psychiatry more like general medicine. General medicine does not incorporate a multiaxial system so psychiatry appears divergent from other areas of medicine in this respect (Wakefield, 2013).

The existing Literature on the latest revision of the DSM points to the following changes in specific disorders as having created the most controversy: autism spectrum disorder (ASD), disruptive mood dysregulation disorder, and the removal of the bereavement exclusion.

According to McPartland, Reichow & Volkmar (2012), the first official recognition of autism was made in the DSM-III. Prior to this time, the term “childhood schizophrenia” (2012, p. 369) was broadly used and included autism. In 1994, the DSM-IV expanded the definition of autism to include asperger’s syndrome (Kanner, 2013). According to Center for Disease Control (2002) there are more children than ever before being diagnosed with ASD. However, it remains unclear how much of this recently observed increase is due to changes in how we identify and classify ASD as opposed an increase in the number people who have autism.

According to APA (2013), the DSM-5 “Depressive Disorders” have several significant changes from the DSM-IV. Bipolar and related disorders are no longer found in this category. In addition, a new diagnosis for children under 12 years of age has been added and is referred to as disruptive mood dysregulation (APA 2013). The APA suggests this change was made in order to address the concerns about potential over diagnosis and overtreatment

of bipolar disorder in children (APA, 2013). Another controversial change that is likely to affect many clients is the removal of the bereavement exclusion from the depressive disorders. According to Grohl (2012), in the DSM-IV, if a person is grieving from the loss of a loved one, you would not be diagnosed with major depression disorder unless the grief persisted past a two month period of time. According to Pomeroy & Parrish (2012), this exclusion was included in the DSM-IV in an effort to not pathologize the normal grief processes or to encourage clinicians to over diagnose major depression.

With a manual as influential and as widely used as the DSM, revisions in the DSM-5 have the potential to disrupt services that are currently being provided and to influence which services are, able, to be provided. This has generated much discussion not only in mental health settings but also in the national media more generally. According to Frances (2013), there is much concern that new diagnoses in psychiatry will be more harmful than helpful to the general population. It may influence whether or not millions of people will be placed on medications, given that such medications are often prescribed in the primary care settings. Patients who only see a primary care physician in lieu of a psychiatrist do not get the same level of attention to psychiatric concerns will not have same level of attention that psychiatry has in making these new diagnosis.

One of the most influential critics to the new DSM-5 is the National Institute of Mental Health (NIMH). This organization has indicated that it will no longer use DSM based diagnostic categories in its research projects (Pomeroy & Anderson, 2013). Insel (as cited in Pomeroy & Anderson, 2013) states that diagnostic categories that are based on clusters of clinical symptoms lack scientific validity when not based on laboratory measurements. He

further disclosed plans for the (NIMH) to create a replacement diagnostic system that is more reflective of biology and modern brain science (Pomeroy & Anderson, 2013).

Ericksen & Kress (2006), counter these criticisms by noting that the DSM benefits clients by giving concrete explanations to the symptoms and experiences they are dealing with. This in turn offers many clients a freedom from self-blame and the ability to focus their energies on managing or resolving their problems (Ericksen & Kress, 2006). Furthermore, Ericksen & Kress (2006), note that clinicians are more apt to have positive feelings towards a client enabling them to be more supportive and less critical.

Social workers provide the largest percentage of mental health services compared to other allied health fields (NASW, 2013). Thus, it is imperative that we be familiar with the changes in the DSM and their impact on social work practice and the vulnerable populations we serve.

Through qualitative interviews with clinical social workers that currently utilize the DSM in their practice, I aspire to gain insight into how implementation of the fifth revision of the DSM will impact the assessment and treatment planning processes.

LITERATURE REVIEW

Development of the DSM

The DSM has undergone many changes and understanding this history will lead to a better understanding and use of this important text (Sander, 2011). According to Sanders (2011), the first edition of the Diagnostic and Statistical Manual (DSM) was an important development towards a standard classification of diseases for mental disorders (See Table 1). Prior to the publication of the DSM-I in 1952, numerous classification systems were used to describe mental illness, leading to a confusing array of terminology to describe similar behaviors and phenomena. This, in turn, made it very difficult for mental health providers to have a common language (Pomeroy & Parrish, 2012, p. 195). When the DSM-I was published, it was a relatively brief manual, consisting of 130 pages with a total of 106 mental disorders. Disorders were initially categorized as either: (a) organic disorders, resulting from structural changes in the brain, and (b) disorders stemming from emotional or mental stresses (Sanders, 2011). The former grouping included brain disorders resulting from infections, dementia and intoxication. The later grouping included psychotic disorders such as manic depression, paranoia and schizophrenia. Blashfield, Flanagan, Raley (2010) noted several features of the earliest DSM. The first is that the major goal of DSM I was creating a classification system for psychiatrists in America to use. "This system was not intended to be a revolutionary document that would alter thinking about mental disorder; instead the values governing its development was pragmatic." In other words, the DSM-I authors did not intend for it to be used by anyone other than psychiatrists. The other feature noted by Blashfield et.al (2010) was that the DSM-I categories were intentionally vague, as they were meant to be used as diagnostic guidelines, rather than strict rules differentiating between separate disorders (Blashfield et al., 2010).

The DSM-II was revised for the first time in 1968. It was only four pages longer than the DSM-I. The major focus of this first revision was to align the DSM more closely with the International Classification of Diseases (ICD), which is the worldwide system for medical and psychiatric diagnosis that was updated and published that same year (Corcoran & Walsh, 2010).

The DSM-II revision included 76 more diagnoses than its predecessor, and grouped disorders according to the following 10 classifications: mental retardation, psychotic organic brain syndromes, nonpsychotic organic brain syndromes (epilepsy, intoxication), psychosis not attributed to physical conditions (schizophrenia), neuroses, personality disorders, psychophysiology disorders, transient situational disturbances, behavioral disorders of childhood and adolescence, and conditions without manifest psychiatric disorder (Corcoran & Walsh, 2010). According to Blashfield et al. (2010), the most significant difference was the removal of the term “reaction” from the title of most of the diagnoses. This was done in an effort to view diagnosis more in relation to a biological etiology rather than an environmental etiology.

The DSM-III represented another major change in the manual. It was published in 1987 and was expanded to 494 pages with a total 265 diagnostic categories (Tartakovsky, 2011). According to Sanders (2010), The DSM-III was centered on descriptive criteria presenting what we now call the medical model and emphasizing, for the first time, an individual’s family history. These changes took into consideration the causes and consequences of the relationships and environments which influence an individual (Corcoran & Walsh, 2010). Moncur & Luthra (2009) note that prior to the addition of the multiaxial diagnostic format, the model for psychiatric diagnosis was relatively simple, taking into consideration only an

individual's symptoms. While the single axis model proved to have a high inter-reliability, it failed to differentiate between two patients with the same diagnosis who had different circumstances and prognoses (Moncur & Luthra, 2009). Tartakovsky (2011) noted that the DSM-III included a total of five axes that related to different aspects of disability or disorder. They included: (Axis I) psychiatric disorders, (Axis II) personality disorder and intellectual disabilities, (Axis III) medical conditions, (Axis IV) environmental and psychosocial stressors, and (Axis V) score based on a Global Assessment of Functioning Scale. Frances (2012) states that the "DSM-III stirred great professional and public excitement by providing specific criteria for each disorder." He indicated that the DSM-III became of interest to the general public and sold over a million copies as people began to consider where they fit amongst the DSM's categories (Frances, 2012).

Unlike the prior revision, the DSM-IV was relatively unchanged from the previous edition. It continued with the multiaxial system and descriptive criteria. Pomeroy & Parrish (2012) noted the most significant change in this addition to be in the number of mental disorders, which was increased from 292 to 365, distributed among 16 categories. A change that brought this DSM addition more in align with a social worker perspective was the inclusion on Axis IV that looked at the patient's psychosocial and environmental problems (Cochran & Walsh, 2012).

Table 1: DSM History

DSM Version	Date Published	Page Numbers	Number of Diagnosis	Significant Changes
DSM I	1952	130	106	First system of Classification
DSM II	1968	134	182	Elimination of term “reaction”
DSM III	1987	494	265	Multiaxial system
DSM IV	1994	886	365	Asperger’s Diagnosis
DSM 5	2013	947	380	Elimination of Multiaxial

Classification Systems

There are several ways which diseases can be classified. The DSM is one type of classification system another, is the ICD. The International Classification of Diseases (ICD) is a standard diagnostic tool for epidemiology, health management and clinical purposes (<http://www.icdx.org>). The benefits of using the ICD is that it provides increased specificity in clinical information that can lead to better quality of patient care and improved disease and care management. The current version of the ICD is the ninth revision, which was developed by the World Health Organization in 1975. The ICD is widely used in the medical health field to classify diseases and health problems recorded on health records (<http://www.who.int/classifications/icd>). It has been over thirty years since there have been any changes to the International Classification of Diseases (<http://www.who.int/classification/icd/en/history>).

The International Classification of Diseases, Tenth Revision, (ICD-10) will go into effect on October 1, 2014. The conversion to the ICD-10 will allow for the accommodation of new procedures and technologies without disrupting the existing coding structure. With the greater detail of the ICD-10 coding system, medical claims will be clearer and diagnoses more consistent with language that substantiates medical necessity (<http://www.rvpi.com/ICD-10>).

The transition to ICD-10 will be one of the largest changes to ever hit health care providers and could have a dramatic effect on revenue streams and operations (AAPC Physician Services, n.d). While many feel this may be of benefit to our health care system, there are others that question whether the cost of such a change will outweigh the benefits received. One thing is certain: that the ICD-10 will impact nearly everyone in the health care field.

Use of the DSM in Clinical Social Work

Social workers must think about and utilize two paradigms: The first is the medical model of DSM diagnosis and the person in environment framework that is the core of social work practice. There are numerous strengths and limitations in the use of the DSM in social work practice. Research conducted by Probst (2012) found that social workers considered the DSM diagnosis more useful for helping clients to better understand their experiences rather than as tool for deciding interventions. In addition, she found that respondents found the DSM useful in communication and continuity of care. Probst (2012) found the following theme among respondents; “that DSM diagnosis served as a starting point and was helpful for psycho-education, validation of a person’s suffering and formulation of realistic hope” (p.187). McQuaide (1999) also summarized both the strengths and weaknesses of the DSM

the following advantages were identified in the DSM: It helps to organize observations and information related to the client's experience, which in turn provides a common language for mental health professionals of different disciplines to share. Categorization allows for the clinician to have more ideas about potential causes and courses of the client's distress and which issues to begin to focus on in the treatment process.

The following is a list of criticism regarding the DSM that McQuaide (1999) found in her research. The first is that DSM categories only provide descriptions and offer no information on etiologies. It is also ethnocentric in that it presumes that diagnostic criteria are universally applicable. It does little to account for many of the problems that social workers are concerned with such as social oppression and economic injustices and tends to defer these to the last pages of the manual under V codes. In addition, the DSM categories can lead to assumptions that if a client does not fit into a category, then he or she does not have a valid emotional issue worthy of treatment. Lastly, McQuaide (1999) identifies specific impacts that the use of DSM has on the clients: It ignores the client's strengths and positive successes in their lives. Moreover, the DSM is not useful in the treatment planning process, as it ignores the context in which mental illness occurs.

Cochran & Walsh (2010) discuss "The Person in Environment Classification System" which is an alternative classification system developed by the social work profession. The PIE framework balances a client's problems and their strengths. It is comprised of assessing four factors, including social functioning problems, environmental problems, mental health problems and physical health problems. This classification addresses two of the major criticisms of the DSM which are the inclusion of relational problems and noting the client's strengths (Cochran & Walsh, 2010).

Organizational changes in the DSM-5

The DSM-5 has been officially released. According to Grohl (2013) The American Psychiatric Association (APA) received over 13,000 comments from 2010-2012, as well as thousands of emails and letters in an effort to allow discussion on the drafts of the manual. This was an unprecedented scale of openness and transparency never before seen in the prior revisions of a diagnostic manual.

According to Wakefield (2013), the DSM-5 manual is organized quite differently than previous manuals in that it is now divided into three distinct sections: Section 1 is the introduction that describes how to use the updated manual and other general information. Section 2 contains the categories of diagnosis that have been revised and organized to demonstrate how disorders are related to one another. This revision is an attempt to group disorders together that have similar underlying etiologies. This section contains the V codes for those conditions that are not considered diagnoses. Section 3 contains those conditions that need further studying before they are introduced as disorders in and of themselves. This section also contains new material on cultural assessment tools.

Another change in the organizational structure of the DSM-5 that is different from previous manuals is that diagnoses are categorized according to specific criteria. According to Pomeroy & Parrish (2012), the DSM-5 is now based on “clusters” of diagnoses. Within each cluster of diagnoses, disorders that have similar characteristics will be listed and described in developmental order from childhood disorders to adult disorders. This eliminates the previous separate section on Disorders Usually Found in Infancy and Childhood.

The elimination of the multiaxial system is of particular concern to social workers. The personality disorders that were formerly listed on Axis II will now be listed as either another primary diagnosis or an additional diagnosis. Wakefield (2013) notes that this change may make it harder for insurance companies to deny coverage for personality disorders as, prior to this change, insurance companies used axis II as a means by which they were able to differentiate reimbursability. According to Kutchins & Kirk (1987) third party payers require a DSM diagnosis prior to payment of services. Payment may also be limited to certain diagnosis and in some more restrictive programs may only pay for treatment that is specifically related to the qualifying diagnosis (Kutchins & Kirk, 1987).

Axis III, which included the general medical conditions, will now be listed as an additional diagnosis (Wakefield 2013). No longer will the environmental stressors and problems in living be addressed in the diagnosis at all, but rather in the section under V Codes. According to Wakefield (2013), this may be useful to social workers, as those factors that influence the target disorder will now constitute full additional diagnoses rather than additional factors outside the diagnosis, potentially elevating their status relative to other factors.

The Global Assessment of Functioning (GAF) has also been eliminated (American Psychiatric Association, 2013). The DSM-5 supports the use of the World Health Organization Disability Assessment schedule as it focuses on functioning and does not depend on symptom levels (Wakefield, 2013)

Changes in Specific Disorders in the DSM-5

According to Pomeroy & Parrish (2012) one of the most controversial changes is related to Asperger's disorder and pervasive development disorder both of which are now be

categorized under the Autism Spectrum disorder (ASD). ASD now encompasses the previous DSM-IV Autistic Disorder, Asperger's Disorder, Childhood Disintegrative Disorder and Pervasive Development Disorder not otherwise specified (APA, 2013). No longer will these disorders be considered as separate disorders. Rather they will be viewed along a spectrum of autism from mild to severe (Pomeroy & Parrish, 2012).

Another major change has been the reduction of the three key dimensions into two, combining social skills and communication into one (Kanne 2013). In the DSM-IV, symptoms were divided into the following three areas: social reciprocity, communicative intent, and restrictive and repetitive behaviors. These new diagnostic criteria base diagnoses on symptoms in the following two areas: 1) social communication/interaction, and 2) restricted and repetitive behaviors (Hyman 2013). According to the APA (2012), the benefits of this change are the provision of more accurate diagnosis, better treatment, and a more consistent application of diagnostic criteria across various agencies and practices.

This change is being criticized by advocacy groups of those who have diagnoses on the higher end of the spectrum who view their disorder as distinct. According to Ben-Zeev et al. (2010), The Asperger's diagnosis is no longer a distinct disorder. Advocates want it to remain unchanged as it differentiates people with this disorder from other people on the autism spectrum. Moreover, this diagnosis has had an important role in helping individuals with this diagnosis understand themselves and communicate their strengths and limitations to their friends and families.

Concern and resistance has also been raised regarding the fear that those who are "higher functioning" will be grouped together and viewed by the public as having the more severe and stigmatized label of autism (Ben-Zeev et al. 2010). McCrory's (2013) views the new

DSM-5's criteria for autism which is divided into the three levels of more, moderate and mild autism may be misleading for those individuals who fall within the mild range of autism.

This broad grouping insinuates that the condition is not very serious and has the potential for individuals who previously had the diagnosis of Asperger's will not fit into the new spectrum. This means they may not qualify for access to government and education programs. This is supported by Pomeroy & Parrish (2013) who also note that there may be less understanding of individuals with milder forms of autism, as they no longer meet the criteria for a diagnosable disorder.

According to the APA (2013), the essential features of disruptive mood dysregulation disorder is frequent temper outbursts that are in response to frustration and occur on average three or more times per week, over at least 1 year, and are present in at least two settings. The second criteria of severe irritability consists of chronic, persistently irritable or angry mood that is present between the severe temper outbursts. These characteristics need to be present most of the day, nearly every day. This diagnosis is given only to children prior to 12 years of age (APA, 2013).

There has been much debate about this new diagnosis. According to (Frances, 2012) disruptive mood dysregulation will turn temper tantrums into a medical disorder. Frances states; "my fear is that it will exacerbate, not relieve, the already excessive and inappropriate use of medications in young children" (2012, p 2). Wakefield (2013) argues in defense of this diagnosis by pointing out the fact that, because this diagnosis falls under depressive rather than bipolar diagnoses, it will reduce the excessive bipolar diagnoses the more harmful medications that are often prescribed in response.

According to the APA (2013), the bereavement exclusion was eliminated from the DSM-5 for the following reasons: first, they wanted to remove the implication that the grief process only lasts 2 months. Professionals who work with grief understand that the duration of the grief process is often more likely to be 1 to 2 years in duration.

Secondly, they felt that bereavement is recognized as having severe psychosocial stressors that can precipitate a major depressive disorder in adults who are predisposed to depression.

Lastly the depressive symptoms related to bereavement are likely to respond to the same psychosocial and pharmacological treatments as non-bereavement disorders (APA, 2013). According to Frances, “normal grief will become major depressive disorder, thus medicalizing and trivializing our expectable and necessary emotional reactions to the loss of a loved one and substituting pills and superficial medical rituals for deep consolations of family, friends, religion and the resiliency that comes with time and the acceptance of the limitations of life” (2012, p. 2).

This view is supported by Pomeroy & Parrish (2012), who believe that by eliminating the bereavement exclusion, individuals experiencing a normal grief process will be labeled with a mental illness and have to deal with the stigma associated with severe depressive symptoms while also dealing with the loss of a loved one. Wakefield states “this category has high potential for abuse, especially if grief becomes targeted for medication development” (2013, p 152).

CONCEPTUAL FRAMEWORK

The recent release of the fifth edition of the DSM-5 creates exciting new opportunities and challenges for social workers practicing in mental health. I will utilize the ecological model and medical model to guide my research. The ecological model focuses on interventions that occur not only with the individual but also within the context of their environments that are inter-dependent of one another.

In the Ecological Model, the social worker not only works with the individual but also intervenes within the family, culture and social factors that are impairing the individual's functioning. Bronfenbrenner (1979) identified "the ecological system as composed of five socially organized subsystems that support and guide human growth" (p. 37). These systems include: Microsystems, Mesosystems, Exosystems, Macrosystems and Chronosystems. Social work has adopted these systems into three broad practice categories consisting of Micro Mezzo and Macro levels of intervention.

The micro level system looks at the relationship between the individual and their immediate environment such as their family, school or work. The mezzo level system looks at interventions from the perspective of the community and the influences it has on the individual's functioning. The macrosystem perspective refers to institutional systems including policies, cultures and traditions that social workers intervene at this level to effect change.

The Medical Model is one, which the physician focuses on the defect, or dysfunction, within the patient, using a problem-solving approach. The medical history, physical examination, and diagnostic tests provide the basis for the identification and treatment of a specific illness (Mosby's Medical Dictionary 2009).

The medical model is widely used framework due to the fact that it is easily understandable and is supported by scientific research on objectives and measurable observations. This, in turn, allows for a similarity among professionals of what each other is talking about and a comfort in knowing that interventions can be defined similarly based on this model. According to Zigmond (1976), the medical model does not lend itself to understanding factors that are outside of measurable and quantifiable data such as the importance of psychological and social stressors on individual. I believe that the ecological perspective offers social workers a greater breadth of data and knowledge by integrating the biological model into the context of a larger system.

METHODS

Research Design

I have chosen to do a qualitative study to explore clinical social worker's perceptions on the recently released fifth edition of the Diagnostic and Statistical Manual (DSM).

The aim of my research is to understand how the assessment and treatment planning processes will be impacted by these revisions. The influence of the DSM in the mental health field is profound. According to Eriksen & Kress (2006), the DSM is an assessment tool that is the primary language of communication that provides professionals with a way of reducing complex client-related information into a manageable form. The DSM further, provides researchers with a scientific method to investigate underlying causal mechanism and processes of particular diagnoses, that can lead to improved control over the outcomes of psychiatric disorders (Eriksen & Kress, 2006).

For this exploratory study I conducted semi-structured interviews with five Licensed Independent Clinical Social Workers. The social workers asked to participate in this study are employed in an outpatient mental health setting that offers services to diverse populations and ages. The social workers are familiar with the DSM and have attended previous trainings where they have been informed on the revision to the DSM manual.

Sample

The study questions focused on the views of professionals who work in the area of mental health and who have experience with the previous DSM editions and are currently using or have knowledge on the recent revisions of the DSM-5. I utilized snowball and availability sampling for this study. According to Berg (2009), the strategy used in snowballing involves identifying several individuals with relevant characteristics and interviewing them. These

participants are then asked for other individuals who have similar knowledge or background. Snowballing sampling allows researchers to locate subjects who interact with one another and share similar characteristics necessary in a study (Berg, 2009).

The sample drew from licensed social workers that are employed in mental health settings where I have been in previous contact with through prior employments. They have experience in using the DSM in the assessment and treatment process.

Protection of Human Subjects

This study was reviewed by a research committee including a St. Thomas instructor within the social work department as well as two MSW's who are Licensed Independent Clinical Social Workers who reviewed the safety of all human subjects. Prior to any data being collected The Institutional Review Board (IRB) at the University of St. Catherine's assured the ethical integrity as well as the protection of the participants.

Prior to interviewing, all participants were given a consent form (Appendix A) that outlines the purpose and procedures of the study and the specific steps that will be taken to ensure the confidentiality of their participation. All interviews were conducted in a private, confidential location. All research data including audio tape recordings and consent forms was stored in a locked file cabinet that only the researcher has access to. All electronic data of the study is kept in a password protected file on the researcher's computer and will be destroyed no later than June 1, 2014.

Participants of the study were informed of any risks involved both verbally and in writing. Participants were able to withdraw from the study at any time without any consequence.

Data Collection

A face-to-face interview was conducted to learn the participants' views on the impact of the DSM-5 on the assessment and treatment planning process. The participants chose the location and time that was convenient, with the only criteria was a private room that would be conducive to discussion without interruption or background noise.

The interview was guided by a questionnaire consisting of ten questions (Appendix B). The first questions are focused on demographic information regarding participant's role within their agency and the years of experience they have with using the Diagnostic and Statistical Manual. The remaining questions focused on themes found in the literature review. Questions were audio recorded and transcribed for data analysis.

Data Analysis

Data collected during interviews was analyzed and interpreted using a grounded theory approach. Grounded theory allows for the theory to emerge from or be "grounded in the data" (Monette, Sullivan, & DeJong, 2011). This method utilizes a continual interplay between data collection, data analysis and theory development (Monette et. al., 2011). Content analysis occurred after the transcription of the interviews had been completed. Berg (2009), describes the process of content analysis as coding and interrupting human communications in order to find patterns, themes, biases, and meanings. I began with a free code approach to analyzing the interview data. From this I developed major codes that clustered common themes.

Strengths and Limitations

There are both strengths and limitations of this study. Based on the qualitative nature of this study, there was a small sample size consisting of five clinical social workers. This small of a sample size makes it difficult to generalize the data beyond the respondents who

participated. The participants were purposefully selected on experience and convenience. Although there are limitations to the study, there are also strengths.

The strength of a qualitative study is that it allowed for me to gain in-depth information. The participants involved in the research possessed specific knowledge on my research topic. Although these are just a few of the strengths and weaknesses, I have identified those that have the most impact on my research.

FINDINGS

There were five participants in the study. All the participants had an MSW and were employed in an outpatient mental health agency at the time of the interviews. The experiences of the social workers ranged from one to 40 years. Four of the participants were female and one male. The participants described their role within their agency as completing diagnostic assessments, supervising the implementation of treatment planning, and providing group and individual therapy to both adults and children who are experiencing mental health issues.

The research study sought to answer the question “What is the clinical social worker’s perception of the revisions in the DSM-5 and the impact these revisions will have on the assessment and treatment planning process?”

There were five major themes identified from the data collected in the interviews: Functions of DSM, stigma, lack of guidance for interventions, subjectivity and reclassification

Functions of the DSM

Three of the participants identified the primary functions of the DSM as being a tool for diagnosing. Two participants identified its primary function as that of facilitating third party reimbursement. The following are quotes from participants regarding the purpose of the DSM.

“Primarily to assign a diagnosis and to look at what kind of treatment we’re offering and making sure the person is hooked-up with the resources they need that connect with the diagnosis.”

“It helps categorize what diagnosis the client fits in. It’s a way of objectively looking at what are the symptoms and what is the diagnosis.”

“Trying to figure out what diagnosis best fits the client, or confirming what the patient is telling me.”

“I don’t think it is useful beyond just a code for billing.”

“Sadly enough, they have to have a diagnosis to be able to get any type of help from insurance...The big deal is the DSM is there to diagnose people, so they can get the insurance coverage to get the help they need,”

Stigma

Three of the five participants expressed opinions on the potential of the DSM-5 to lessen the negative stigma perceived by the individual seeking treatment.

“The DSM-5 lends itself to not creating such a stigma in that, all of the diagnoses will be in one spot, right up on top so you won’t be so focused on whether it’s some intellectual difficulties, or if it’s a personality disorder; I think not having it separated will help with less stigmatizing of these disorders.”

Another participant reported:

“Having the medical and mental health diagnosis located on the same line will look at the whole person rather than separating them out... I think that’s a healthy way to treat people.”

According to a third participant,

“I think there could be some de-stigmatizing of the way personality disorders are viewed [using the revised DSM]. The way it’s been previously categorized, it’s been

thought of as a long term chronic condition that can influence people negatively so as not to see the potential of the person.”

Lack of guidance for interventions

There was a prevalent theme among the participants that the DSM is not a useful tool in guiding the treatment plan process. One participant explained it this way:

“There is a huge disconnect between the diagnosis and the treatment plan... two people can be labeled with Schizophrenia, one can be in psychic pain which would require one type of intervention while the other may be immersed in their delusional system and be quite comfortable with it.”

Another participant also described the lack of focus on interventions when asked about what changes they would propose to the DSM?

“I would have more of a connection between the diagnosis and the intervention... there are clinicians out there...are great at looking stuff up. They are great at looking in the DSM, ICD, whatever, and diagnosing, but what do we do from there? How do you guide your staff?”

Another participant stated it this way:

“The focus needs to be less on labeling a problem and more focused on the strengths of the client and what they want and how we are going to help them to reach their goals.”

Subjectivity

Three of the five participants identified that the elimination of the multi-axes, specifically the Global Assessment Functioning (GAF) score, was a positive change that was made in the latest revision of the DSM-5. One of the participants is quoted as

“I definitely think it’s positive that they are getting rid of the GAF score, because I never felt that it was the slightest bit reliable.”

This participant went on to say:

“I have seen chart after chart where umpteen people will rate a person, and they are all equally well trained, whether they are a psychiatrist or a PHD psychologist, [yet] the point spread is huge.”

The participant further critiques

“...that it ends up just being something people have to do to show that they’re showing improvement or not or I have to show that they’re not doing well and the we can justify [the patient] being in a hospital. It just didn’t seem a very useful measure to me at all.”

This viewpoint was supported by another participant who reported,

“The GAF was not helpful at all. It’s so subjective. It’s just weird how different clinicians will look at the same person with the same functioning at the same time, and we’ll have five different scores.”

The participant further explains how the GAF score tends to vary based on the individual characteristics of the rater, as opposed to the subject being rated.

“It’s the personality of the clinician, it’s how the client is presenting in your own perception, every person has a different perception, the question that they answered that day and how they answered it is so subjective. It’s not very helpful at all so I’m glad that’s gone.”

Another participant agreed:

“I think that getting rid of the GAF score will be great, because that put an artificial, weird label on someone...where as one clinician might give them a GAF score that’s super low, and another’s is super high, and it just might end up labeling them in a way that just doesn’t feel right... there doesn’t necessarily seem to be a lot of validity going on there. So getting rid of that I think is a positive.”

Reclassification

Three of the participants discussed their concerns that the elimination of the Asperger’s Diagnosis may reduce the services and resources to those individuals who now are being reclassified into the autism spectrum disorder. A participant is quoted as follows:

“I think there is concern for people that formally have been given a diagnosis of Asperger’s need support and coaching to be able do as much as they can and [I fear they] will not be able to get those resources to help them.”

This participant describes a further concern;

“Not everybody in the spectrum really looks the same, and maybe there is a useful distinction between Asperger’s and autism. It seems like there is and that the distinctions will be blurred.”

Another participant agreed;

“It worries me as I’ve met and treated several kids with Asperger’s, and I think they definitely need a lot of support and [I worry that] people that have less severity of autism will no longer be eligible for services.”

Another participant echoed these concerns about the ease of access to autism specific services as the DSM-5 take effect:

“I think there will be a lot more work into proving that a child really needs services, that their problems are severe enough if they are not in a specific Asperger’s category which I think is a concern.”

DISCUSSION

This study focused on the revisions of the DSM-5 and the perceptions that licensed clinical social workers feel will impact the assessment and treatment planning. The DSM is the predominant diagnostic classification system among clinical social workers in the United States. Knowledge of the DSM is critical so that social workers can communicate with other mental health professionals and to be eligible to receive reimbursement for services they deliver. Themes emerged from this study that are consistent with what the literature would have predicted.

Functions of the DSM

The literature details a brief history beginning with the DSM-I that was developed in 1952 and underwent numerous revisions up through the most recent edition, the DSM-5 in 2103. The DSM-5 is discussed in relation to the differences from its predecessors, particularly the move from a five axes system to a one axis system. The consensus from the respondents studied is that the current DSM has served the utilitarian purposes of providing a vehicle for communication between mental health professionals and for helping clients better understand their experiences.

Stigma

A majority of participants in the current study believe that the elimination of the multi-axes would lead to clients experiencing less stigma, especially in relation to those diagnosed with a personality disorder. These findings are supported in the literature by studies suggesting that those clients with former Axis II diagnoses may now find it easier to navigate mental health treatment under the new classification of DSM-5, as they will no longer be seen as having a diagnosis that is more difficult to treat than other diagnoses (Wakefield,

2013). This positive shift is felt to be the result of the shift from the five axes classification system to placing all diagnoses on one axis.

Lack of guidance for interventions

All five participants in the study agreed that the DSM was useful for the purposes of educating individuals about their condition and giving all mental health professionals a common language with which to discuss mental health diagnoses. However, they felt the DSM is lacking in its utility for clinicians in that it does little to help determine probable causes of disorders and offers no suitable interventions to reduce or eliminate the presenting problem. The literature supports the participants' views that the DSM's focus on symptoms and pathology simplifies the complexity of mental illness and does not take into consideration how the individual is experiencing his or her symptoms or the relevance of the social context.

Subjectivity

It was surprising to me that 3 of the 5 participants specifically identified the Global Assessment Functioning (GAF) scale as having limited validity as they felt it was subjective to the clinician's perceptions. The DSM-5 has eliminated this scale and is now supporting the World Health Organization Disability Assessment schedule. The literature supports the views of the participants in the current study by identifying the major limitation of the GAF as mixing all domains of functioning into one index that leaves it up to the clinician to determine where to rate an individual (Dimsdale, Jeste & Patterson 2010).

Reclassification

The concerns cited by participants in the present study regarding the elimination of the Asperger's diagnosis is also supported by the literature. Specifically, Pomeroy & Parrish

(2012) identified one potential cost of the reclassification will be that individuals previously diagnosed with Asperger's may no longer qualify for a diagnosis of an Autism Spectrum Disorder. In addition they cite concerns about the lack of recognition given to individuals with milder forms of autism and their symptoms, as they no longer meet the criteria for a diagnosable mental disorder (Pomeroy & Parrish, 2012)

Implications for Social Work

The DSM 5 has created more diagnostic categories that will have the net effect of labeling an increasing number of individuals as "mentally ill." France (2012) stated that many millions of people with normal grief, distractibility, and reactions to stress will be mislabeled as psychiatrically sick and given inappropriate treatment. This is of particular concern to social workers, as they constitute the largest number of mental health professionals in the current mental health workforce. In the face of this escalating pressure to do more and serve more with less, social workers should be cautioned to limit the influence of the biomedical model on our professional thoughts and actions. Social workers must continue to critically examine the circumstances of the individuals they serve from a social work perspective and not lose sight of the multi systems perspective that makes them unique. Social workers are trained to not look only at individual psychopathology but to use a broader lens in understanding the complex nature of an individual's problem rather than only dealing with the surface level symptoms.

Implications for Policy and Research

The recovery model has been a model that has been increasingly supported through policy and practice in the treatment of persons with mental illness. In recent years, the notion of recovery has moved away from the traditional clinical definitions of recovery as that of a

judgment by an external observer and places great emphasis on symptom reduction (Slade, 2009), to more emphasis on a personal recovery model. This model views recovery in relation to the subjective experience of the individual identified as the client, including identifying their personal goals and ambitions that are independent of symptom reduction (Slade, 2009). The DSM-5 does not incorporate a recovery model that allows for a personal sense of recovery that is distinct from the person's symptoms. Rather the DSM-5 intent is to be able to readily update the manual as changes emerge in the understanding of brain science. However, in order to maintain a more balanced perspective on mental health diagnosis and treatment, I would argue that updates to the DSM moving forward should also include changes in the context of the shifting cultural and social perspectives.

CONCLUSION

With the recent release of the DSM 5, there have been significant changes that have generated a lot of discussion among social workers. The most controversial of these has been the changes made in relation to Asperger's Disorder. Individuals, families and advocacy groups have been vocal in their frustrations with the elimination of this disorder. They see Asperger's as a different condition from autism and disagree with the decision to eliminate it as a separate disorder. The other change which has generated much debate is the loss of the multiaxial system. The five axes used to formulate a diagnosis have been around since 1987, starting with its inception in the DSM-III. The five aspects of a diagnosis are no longer going to be listed in the diagnostic description. Instead, diagnoses will be recorded in a single list, with the primary diagnosis first with others following in order of importance to treatment.

Along with the controversial changes there are other changes within the DSM 5 that social workers feel are positive. One of these changes is that personality disorders will now be listed on one line with other primary diagnoses. This change has the potential to reduce negative stigma associated with persons diagnosed with Borderline Personality Disorder. Another positive change is the inclusion of several new diagnoses in this addition, including hoarding disorder, which will open up an opportunity for treatment to these individuals who previously were invisible from diagnostic standpoint.

This is an exciting and challenging time as clinicians begin to adapt to the new manual. As social workers who utilize the person in environment framework, we must not forget that there are many influences that affect a person and our goal is to not only focus on deficits but also pay equal attention to the strengths inherent in each individual.

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Appendix A

Clinical Social Worker's Perception of the Impact of Revision of the DSM-5 INFORMATION AND CONSENT FORM

Introduction:

You are invited to participate in a research study investigating the impact of the DSM-5 on the assessment and treatment process. This study is being conducted by Tara Jenó a graduate student at St. Catherine University under the supervision of Dr. Rajean Moone, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because of your experience in the use of the DSM in your work doing clinical diagnostic assessments. Please read this form and ask questions before you agree to be in the study.

Background Information:

The purpose of this study is to explore the impacts of the implementation of the DSM-5 on the assessment and treatment process. Approximately 7 people are expected to participate in this research.

Procedures:

If you decide to participate, you will be asked to participate in a face-to-face interview with the researcher. The interview will consist of ten questions about your experiences with the DSM and your views on the impact of the DSM-5. This study will take approximately one hour and will involve one session.

Risks and Benefits of being in the study:

The study has minimal risks. The topic of treatment planning and assessment in relation to the DSM-5 has a potential to produce negative and uncomfortable emotions regarding categorizing individuals into mental pathology. In order to minimize these risks you have the right to stop the interview at any time and refuse to answer any questions that make you feel uncomfortable.

There are no direct benefits for participating in this research study

Confidentiality:

Any information obtained in connection with this research study that can be identified with you will be disclosed only with your permission; your results will be kept confidential. In any written reports or publications, no one will be identified or identifiable.

I will keep the research results in a locked file cabinet and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 31, 2014. I will then destroy all original reports and identifying information that can be linked back to you. The types of records I will create include audio-recordings, transcripts and hand written records. The consent forms and audio records for this study will be kept in a locked file cabinet. All electronic information will be kept in a password, protected computer.

Voluntary nature of the study:

Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:

If you have any questions, please feel free to contact me, Tara Jenö, at 507-456-6123. You may ask questions now, or if you have any additional questions later, the faculty advisor, Mr. Rajean Moone at 651-235-0346 will be happy to answer them. If you have other questions or concerns regarding the study and would like to talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739.

You may keep a copy of this form for your records.

Statement of Consent:

You are making a decision whether or not to participate. Your signature indicates that you have read this information and your questions have been answered. Even after signing this form, please know that you may withdraw from the study at any time.

I consent to participate in the study. I also consent to be audio-taped during this interview.

Signature of Participant

Date

Signature of Researcher

Date

Appendix B Interview Questions

Interview Questions- Social worker's views on impact of the DSM-5

Interviewer: Tara Jenó

Demographics: Male or Female Race: _____ Age: _____

1. What is your role as a social worker within your agency?
2. How long have you been a Licensed Independent Clinical Social Worker?
3. How long have you been using the DSM?
4. What are purpose/functions of the DSM in your practice of social work?
5. What purpose do you believe a patient's diagnosis serves within your agency?
6. In what ways do you think the changes in the DSM-5 will improve clinical care?
7. In what way do you think the changes in the DSM-5 will negatively affect clinical care?
8. As a social worker what impact do you believe the elimination of the multi-axial system will have on treatment planning?
9. There has been much controversy regarding the diagnosis of Asperger's being renamed Autism Spectrum Disorder, What do you think the impact of this will be on children who had this previous diagnosis?
10. What changes would you propose making to the Diagnostic Statistical Manual?
11. Is there any additional information I did not ask that you would like to share?