THE DIAGNOSTIC MANUAL (DSM-III) AND SOCIAL WORK PRACTICE

Karen A Holmes and Paul R Raffoul, University of Houston, Texas

INTRODUCTION

Controversy among social work educators and practitioners regarding the use or abuse of diagnostic labels has been revived with publication of the *Diagnostic and Statistical Manual of Mental Disorders* (1980, 3rd ed) by the American Psychiatric Association. We will use the common reference, *DSM-III* for this manual. For years, labeling theorists and critics of the prevailing medical model of therapy have warned mental health practitioners about the negative consequences of applying diagnostic labels to institutionalized persons, to those in therapy, or to those who fail to conform to society's expectations (Scheff 1974; Szasz 1961, 1976; Rosenhan 1973). Nonetheless, while the social work profession has remained somethat divided on the issue of diagnostic labels, the prestige and authority of the medical profession have continued to influence many functional aspects of social workers' practice, including that of diagnosis.

THE ISSUES

According to the American Psychiatric Association (APA) Task Force on Nomenclature and Statistics, whose job it was to guide the development of their diagnostic manual, DSM-III, the purpose was to classify and describe mental disorders (Spitzer et al 1980 152). In addition to defining mental disorders, the Text Editor, Williams (1981), who is also a social worker, notes that DSM-III includes the official codes and corresponding terms for all mental disorders recognized by the APA, and operational definitions and descriptions for each category of disorder. In Williams' view, the manual "... truly represents the most advanced development in diagnosis (and) ... Social workers must become familiar with DSM-III." (Williams 1981 101, 106) Williams feels that one of the most important new features of DSM-III which is particularly relevant for social work, is the comprehensive multiaxial system for evaluation. The DSM-III is said to provide: 1) comprehensive operational definitions of the recognized disorders; 2) greater diagnostic reliability than before; 3) a new 5-axis classification system. The system provides a comprehensive psycho-bio-social approach to evaluation (Williams 1981 102).

Williams cites three specific reasons for her position. First, if accurate diagnosis suggests the most effective treatment, and if social workers are responsible for diagnosis and treatment planning, then social workers:

> must become familiar with current standards for acceptable practice. Second, to maintain their position as respected members of multidisciplinary treatment teams, social workers must be able to communicate with their medical colleagues ... Third, DSM-III can serve as a comprehensive tool for learning ... about psychopathology ... and about mental disroders." (Williams 1981 101)

On one side is the position that social workers must be knowledgable about the DSM-III in order to improve the quality of diagnosis and the quality of treatment, and be able more effectively to communicate with other mental health professionals such as psychiatrists and clinical psychologists. Opposed is the argument that diagnositic labels of mental disorders are not within the purview of social workers, and further, that labeling itself has negative consequences. In particular, there are data suggesting that women, minorities of color, and lower income groups tend to be labeled with greater frequency and more pejoratively than other client groups (Dohrenwend, Chin-Shong 1967; Brenner 1982 48). However, the addition of Axis 4 and Axis 5 to the diagnostic manual, DSM-III while not a part of the "official" diagnosis, may be an attempt to offset some of the concerns expressed by the labeling critics. Specifically, Axis 4 provides a means of evaluating the severity of psychosocial stressors in the 12 months preceding the onset or worsening of the disorder. Axis 5 provides a way to assess the individual's adaptive functioning during the previous year. Our question now is: "To what extent are the five axes of the DSM-III diagnostic manual being utilized by social work practitioners?"

PURPOSE OF THIS STUDY

This is an exploratory-descriptive study that

provides information about current utilization patterns, and perceived advantages and disadvantages of DSM-III among practicing social workers. The research objectives are: 1) Identify and describe the extent to which DSM-III is used by social work practitioners in a variety of settings. 2) Determine the influence of practice settings and practitioner demographic variables on utilization or non-utilization of the DSM-III by social workers. 3) Identify and describe advantages and disadvantages of DSM-III utilization for social workers. 4) Explore the perceived influences of the DSM-III nosology on social work practice, with particular attention to Axis 4 and Axis 5.

METHOD

Study Instrument and Data Collection Procedures. A 15-item self-administered questionnaire was developed to gather data on utilization patterns and perceived advantages and disadvantages of DSM-III, and demographic and descriptinve professional variables from a sample of social workers. Respondents were solicited at a recent state conference of the National Association of Social Workers (NASW).

This approach was taken in an attempt to maximize the probability of obtaining a representative sample of social work practitioners across the state of Texas from a variety of practice settings, and with a heterogeneous utilization pattern relative to DSM-III. The respondents were sampled in two groups at the conference: a pre-conference workshop on DSM-III and a general meeting of the Texas Society of Hospital Social Work Directors. A total of 140 questionnaires was distributed, and 53 questionnaires were returned yielding a response rate of 38 percent.

FINDINGS

Study Sample. For data analysis, the study sample was divided according to frequency of DSM-III use as *Always*, 26 percent; *Sometimes*, 28 percent, and *Never*, 45 percent. With few exceptions, all respondents were Masters' level social workers. Demographic, professional, and work setting variables are presented by group in Table 1. There are statistically significant differences using one-way analysis of variance on all age

TABLE 1: CHARACTERISTICS OF STUDY SAMPLE BY USE OF DIAGNOSTIC MANUAL

	Always n = 14	Sometimes n = 15	Never n = 24
Age*			
Mean	42	37	34.5
Range	24-58	26-55	27-48
Sex			
Male	7	7	6
Female	7	8	18
Years in Practice*			
Mean	12.3	5.2	6.6
Range	1-34	2-10	1-13
Years in Position*			
Mean	5.9	2.3	3.0
Range	1-19	1-5	1-9

*p ◄ .05, 1-way analysis of variance

TABLE 2: PERCEIVED ADVANTAGES OF DSM-III BY FREQUENCY OF USE

	Always n = 14	Sometimes n = 15	Percent n = 29
Meets agency requirement	11	2	45
Enhances diagnosis	10	12	76
Saves time recording	5	—	17
Communication with colleagues	9	9	62
Treatment planning	9	9	62
Understanding patients	9	8	59
Insurance reimpursement	5	7	41
Total responses	**58**	**47**	

TABLE 3: DISADVANTAGES OF DSM-III BY FREQUENCY OF USE

	Always n = 14	Sometimes n = 15	Percent n = 29
Labels clients	2	7	31
Value conflicts	1	3	14
Too little training	--	2	7
None	11	5	55
Total responses	14	17	

variables between groups. As shown in Table 1, the older respondents were significantly more likely to be the more frequent users of DSM-III, with the youngest respondents in the *Never* use category. Consistent with age findings, the more frequent users also were significantly more likely to have the most years in practice, averaging 12.3 years, compared with 5.2 years for the *Sometimes* users. Using the Neuman-Keuls test for within-group differences, the older, more frequent users had significantly more years in their position, with 5.9 years average, compared to 2.3 years, average time in position. No differences were found in work setting by frequency of DSM-III usage. In terms of theoretical orientation, nearly half, or 45 percent of the respondents described themselves as *eclectic*, followed by *psychodynamic*, 17 percent; *behavioral*, 6 percent, and *Gestalt*, 2 percent.

Utilization of DSM-III.

Is is surprising to find that only 29 of the 53 respondents, or 55 percent, report using DSM-III in their practice. We did not expect this, with two-thirds of the sample employed in hospital settings. This is more interesting considering responses to the question: "Who determines use of DSM-III?" Nearly all, or 93 percent of those who always use DSM-III are required to do so by their agencies. Among the *Sometimes* users, 47 percent chose to use the DSM-III by individual option. In all, 72 percent of the usage is because it is required, and 28 percent choose it as a matter of preference.

Advantages & Disadvantages of DSM-III.

To identify and describe th perceived advantages and disadvantages of DSM-III, respondents were asked to indicate specific advantages and disadvantages of the system. Table 2 provides a summary of those responses according to frequency of use. Three-fourths of the respondents said that use of DSM-III enhances their diagnostic skills. One said that it helps to differentiate between diagnoses, and another said that it lends specific criteria to the diagnostic process. And 62 percent said that DSM-III facilitates communication with colleagues and the development of treatment plans, while 59 percent said that it helps in understanding patients. One observed that it was helpful to look at all five axes in the diagnosis. Only 45 percent cited *meeting agency requirements* as an advantage, and most of these were in the *always use* group. The only respondents who cited time saving in case recording as an advantage were in the *always use* group. Less than half saw the DSM-III as an advantage in receiving third party payments.

Four clear responses evolved in relation to perceived disadvantages (Table 3). Most, or 55 percent saw no disadvantages, but those who did see disadvantages cited the effect of labeling clients as such. Most of these negative perceptions came from the *never* and *sometimes* use groups. Clearly those who always use the DSM-III, and are required to do so by their agency support use of the DSM-III system, but here are some specific issues being raised in relation to DSM-III. One respondent was concerned that the therapist could easily get caught up with clinical diagnosis, and reify the label rather than treat the unique person. Another thought that DSM-III tends to be a standardized method to classify and quantify human behavior.

Axis 4 and Axis 5.

Because of the potential relevance to social work practice for Axis 4, *Severity of Psychosocial Stressors*, and Axis 5, *Prior Adaptive Functioning* for treatment planning, all users of DSM-III were asked to identify from a select list, the specific purposes for using each axis. Using the Kolmogorov-Smirnov test, findings indicated that users significantly more frequently selected "definition of current condition" and "planning treatment" as the major reasons for asking about stressful events ($D = 0.15$, $p < .05$) When respondents were asked to rank their responses related to the purpose of these axes, 1-4 from most to least useful, more respondents chose "definition of condition" than any other category. This finding was statistically significant by the Kolmogorov-Smirnov test ($D = 0.97$, $p < .05$). The same responses were solicited for Axis 5 with similar findings. Again, most respondents selected "development of prognosis" and "planning treatment" as the purpose for asking about prior social functioning ($D = 0.97$, $p < .05$). However, when asked to rank the usefulness of their choices, respondents ranked "definition of condition" significantly higher than "planning treatment

(D = 0.99, p ◄ .05). In both cases, DSM-III users appear to be familiar with the appropriate purpose for Axes 4 and 5, but do not relate this to their usefulness in practice. For this study, verification of current diagnostic label is the most important use of Axis 4 and Axis 5.

SUMMARY AND IMPLICATIONS

Only about half of the social work practitioners who responded to the questionnaire are current users of the diagnostic manual, DSM-III, and among those, the use of the manual is dictated by the employing agency. No one theoretical orientation was found to distinguish users from non-users. Older and more experienced respondents were more likely to use it than were younger and inexperienced practitioners. Enhancement of diagnostic skills was the most frequently cited advantage of DSM-III, but most repondents reported multiple advantages, which raises the question of whether attempts were made to discriminate among the various uses of DSM-III. The 29 social work practitioners who use the instrument gave 105 responses in the citing ways in which the system is useful, and only 15 disadvantage responses. Over half saw *no* disadvantages of any kind with the DSM-III. Overall, the diagnostic manual, DSM-III tends to be viewed in a positive light by social workers who regularly use it in practice.

Multiaxial Evaluation vs. Labeling Implications for Practice.

Presuppositions of this study were that diagnosis and evaluation: 1) are within the knowledge and skill boundaries of social work; and 2) are ethically congruent with the values and goals of the profession. But some social workers would argue that diagnosis whether based on one axis or five, is not an appropriate function of social work because of the potentially dangerous consequences of labeling. Others could argue against DSM-III on the grounds that it reflects the increasing movement toward "medicalization" of social and behavioral dysfunctions which may not be medical or mental disorders. When the DSM-III was first published in 1952 it contained 60 disorders; in 1968 there were 145 disorders (Garmezy 1978). The 1980 edition contains 230 disorders. Under Axis 2, some of the children's "mental disorders" included *Specific reading disorder, Attention deficit disroder, Shyness disorder,* and *Developmental articulation disorder*, to name a few examples (Garnezy 1978 4).

It is important to note that our respondents who indicated that the primary use for Axes 4 and 5 was to define the condition rather than to assist in planning treatment. This suggests that while social workers' concerns about the negative effects of labeling prevent them from using the DSM-III in treatment planning, they find the system a useful tool for communicating with medical colleagues.

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