

SOCIAL WORK AND THE DSM

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The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association, now in its fourth edition, sets forth a diagnostic system with objective diagnostic criteria that uses five axes: axis I for clinical syndromes; axis II for personality disorders and mental retardation; axis III for physical disorders and conditions; axis IV for psychosocial stressors; and axis V for global assessment of functioning.

Clinical therapists often use the *DSM's* diagnostic system (in particular axes I and II) to diagnose a mental disorder preliminary to treatment.¹ A *DSM* diagnosis may be a prerequisite for a provider's reimbursement by government agencies and private insurers alike. Treatment plans and medication may be selected on the basis of diagnosis. Once assigned, a *DSM* label may become as much a part of an individual's medical record as a history of rubella or chicken pox.

Although the *DSM* is the creation of an organization of psychiatrists, it is now employed extensively by social workers, a development that has been attributed to the requirements of state examinations for professional licensing, the increased employment of social workers in mental health settings, the proliferation of *DSM*-related resources for counselors, and the emergence of programs sponsored by the American Psychiatric Association (APA) for training counselors in psychiatric diagnosis using the *DSM* (Kutchins & Kirk, 1986; Velasquez et al., 1994).

The *DSM's* increasing dominance of the mental health field has created a professional boundary problem for nonmedical practitioners. What does a manual that embodies the values, assumptions, and outlook of the medical profession offer social workers? Can social workers use it in ways that benefit their clients? If use of the *DSM* is mandatory, how can it be integrated into a practice that upholds the long-standing ideals of the

social work profession? The present chapter considers these questions in the context of broad ethical issues and other concerns that have been voiced about the *DSM* in its various editions.

HISTORY OF THE *DSM*

As the tool of mental health practitioners, the *DSM* is of fairly recent vintage. The ancient Greeks described madness and its subtypes, but until the second half of the twentieth century, the medical profession contented itself with a few unofficial broad categories. Epidemiology spawned the modern preoccupation with classification, as it promoted the counting and sorting of people (Kirk & Kutchins, 1992). Imitating the approach of medicine, and accommodating the scant knowledge of etiology by focusing on overt symptoms rather than causes, psychiatry in the person of the German doctor Emil Kraepelin in the late nineteenth century produced the first taxonomy of mental disorders.

In the United States the federal census takers nurtured the classification of mental disorders. The 1840 census included the term "idiocy," understood to encompass insanity. By 1880 seven terms had emerged, but not until after 1904 did census officials pursue a psychiatric taxonomy in earnest. The American Medico-Psychological Association, the predecessor of the American Psychiatric Association (APA), at the government's request produced the first standard, the *Statistical Manual for the Use of Institutions for the Insane*, which enabled the diagnostician to choose from 22 categories. Despite criticism from some psychiatrists, notably Adolf Meyer, who cautioned his colleagues that the use of one-word diagnostic labels was fraught with hazards, the manual went through 10 editions between 1918 and 1942. The experience of psychiatrists working with combat veterans during World War II gave rise to the next nosology, which reflected greater concern with the role of the environment and with less severe forms of mental disturbance and placed greater stress on psychodynamic and psychoanalytic perspectives. The *DSM-I*, produced in a year by an appointed working group, was published in 1952.

The *DSM-II*, which was prepared by an APA committee in three years and was published in 1968, increased the number of recognized diseases and encouraged users to give the patient more than one diagnosis. It also eliminated use of the term "reaction," which in the *DSM-I* had reflected the psychobiological view of Adolf Meyer that mental disorders were responses to psychological, social, and biological factors. Like its predecessor, the *DSM-II* embodied the current practice of psychiatry. The suc-

cessor editions, the *DSM-III* and the *DSM-III-R*, were published in 1980 and 1987, respectively.

The *DSM-III* brought a descriptive, atheoretical approach to classification with objective diagnostic criteria and introduced the five-axis diagnostic structure. The manual was touted as providing "the most up-to-date and valid criteria for diagnosing mental disorders," a new classification system that "should lead to improved treatment of [social work] clients" (Williams, 1981, p. 101). Nevertheless, critics expressed concern about the value-laden language and the objective stance taken by the manual.² Cutler (1991) offered the following interpretation:

The *DSM-III* places the maximum amount of distance between clinician and client through their position as dualistic opposites. . . . The reason for distance in the first place [becomes apparent from their opposition]; the distance is based on clinicians' desire to see clients as other than themselves; the desire is based on clinicians' fears of being or becoming like clients—sick, confused, hurt. Distance allows the clinician to view the client as other without having to examine self in relation to mental disorders. (p. 157)

The *DSM-III-R* during its preparation received considerable publicity in connection with proposed diagnoses regarded as being unfair to women. Misgivings were also expressed about the way in which diagnostic categories were established and about control of the decision-making process (Kutchins & Kirk, 1989a; Kirk & Kutchins, 1992; Caplan, 1995). The timing of revision and publication meant that data needed to assess the empirical basis for a new edition were not available until after it had been published (Kirk & Kutchins, 1994). The *DSM-IV*, currently in use, was published in 1994.

With each successive edition, the number of diagnostic categories has mounted. In one survey, psychiatrists complained that the *DSM-III* focused on signs and symptoms so much that it detracted from understanding, promoted a "cookbook approach" to assessment, and misrepresented the current state of knowledge regarding mental disorders (Kutchins & Kirk, 1988, p. 215). While it has been suggested that the *DSM* is merely an effort to organize behavioral manifestations in a field that is "still far from scientific clarity" (Anello, 1989, p. 186), questions about proposed new disorders have spawned questions about the manual's basis in clinical trials and about its validity and reliability (Mattaini & Kirk, 1991; Kirk & Kutchins, 1992).

Proponents of the *DSM-III* declared that it solved the central scientific problem of unreliability by providing "explicit diagnostic criteria that made diagnosis more systematic and replicable" (Widiger et al., 1990, p. 190). Field trials of proposed *DSM-IV* criteria were said to have yielded a high rate of agreement across sites and between raters (Kline et al., 1993). Studies of reliability typically refer to *kappa*, a measure of the extent of agreement between raters (clinicians diagnosing the same patients); a *kappa* of 0 indicates chance levels of agreement, whereas a *kappa* of 1.0 indicates perfect agreement.

Comparison of *kappa* ranges for studies of different editions of the *DSM* suggests that reliability has remained approximately the same for three decades, from the publication of the *DSM-II* to the present day (Kutchins & Kirk, 1986; Kirk & Kutchins, 1994). Furthermore, the statistic has several inherent problems. First, a given level may be interpreted differently, depending on the study (if, as has been claimed, no major diagnostic category in the *DSM* achieved a *kappa* of .70, should this standard be regarded as poor, satisfactory, or quite good?). Second, *kappa* responds to hidden factors that may not be immediately apparent from discussions of results. These factors include variations in sensitivity (the tendency of the clinician to make a positive diagnosis when a disorder is present), specificity (the tendency of the clinician to make a negative diagnosis when a disorder is absent), and the base rate, or prevalence of the disorder in the population under study (Kutchins & Kirk, 1986; Kirk & Kutchins, 1994).

Indeed, patients may be diagnosed differently by clinicians for many reasons.

It is well established that unintentional diagnostic mistakes in mental health are commonplace, whether due to the limits of professional knowledge, the inadequacy of clinical training, or the unreliability of diagnostic classification systems. But mistakes stem not only from the limits of knowledge and technique or from careless practice but also from perceptual distortions that occur in interaction. For example, we know that social context affects the psychiatric interpretation and labeling of behavior. Clinicians' assessments are also unwittingly influenced by suggestions or prior labeling by colleagues. And, of course, there are situations where two clinicians simply disagree about the diagnosis. This situation is frequently illustrated by contradictory psychiatric testimony provided at criminal trials. These events, and a host of diagnostic stud-

ies, suggest that psychiatric diagnosis is easily influenced and unreliable. (Kirk & Kutchins, 1988, p. 227)

The five-axis approach, designed to make possible a more balanced assessment of biological and environmental factors contributing to mental illness, has also inspired some misgivings. Although axis IV has been welcomed because it introduces environmental concerns into the diagnostic formulation, the identified stressors may—confusingly—be both cause and consequence of mental disorder (Kirk, Siporin, & Kutchins, 1989, p. 301). Some concern has also been expressed about the use of the *DSM* by nonmedical practitioners on the ground that axis III calls for an evaluation of organic conditions, which physicians alone can perform (Kutchins & Kirk, 1987).

Within the medical profession the fit between disorder and enumerated symptoms has been the subject of debate. The manual's critics have attacked the effort to categorize symptoms as environmental or biological in origin without acknowledging that all disorders reflect gene-environment interactions: "Genes affect the relevant environment for psychological development as much as the environment affects the expression of genes" (Hyman & Nestler, 1993, p. 202). Indeed, the biological/psychological dichotomy is increasingly being discredited: "Urgently needed advances in the diagnosis, treatment, and prevention of severe mental disorders depend on the identification of specific neuronal and intracellular factors involved in the pathophysiology of specific diseases" (Hyman & Nestler, 1993, p. 203). Moreover, the utility of the *DSM*'s diagnostic categories would be compromised if phenotypically indistinguishable psychiatric disorders were found to be genetically heterogeneous in etiology or due to environmental causes, as may well be the case (*ibid.*, p. 207).

Apart from disputes about the *DSM*'s validity and reliability, there has been broad controversy about the relationship between classification and assessment.

SCIENTIFIC CLASSIFICATION

Diagnosis entails translating subjective experience into an objective list of symptoms that fit into a codified diagnosis (Cutler, 1991). Like other forms of categorization or classification, diagnosis summarizes information for administrative purposes, defines conceptual categories in a way that gives structure to research, promotes communication between professionals, and facilitates the control or prevention of undesirable events.

Systems that involve such classification, it has been noted, can distort phenomena. Diagnosis alters the information available to the clinician. Rather than illuminating the full range of a client's attributes, diagnosis highlights some parts, obscures others, and subtly suggests that a hitherto unnoticed but nonetheless independently existing entity—a disorder—has been discovered. This tendency is sometimes derogated as assigning blame (implying deficiency) and suppressing the wealth of contextual information that is often present in descriptions (Mattaini & Kirk, 1991). Social workers have traditionally been ambivalent about the value of classification, in part from professional distrust of standards that threaten to be judgmental (Kirk, Siporin, & Kutchins, 1989; Abramovitz & Williams, 1992).

In addition, the *DSM* presents a fixed-rule diagnostic system: the diagnostic criteria do not alter across settings. Fixed-rule systems of classification have been faulted for failing to take into account variations in treatment practices that relate to region, time, situation (whether research or practice), and clinician (Finn, 1982).

Diagnosis need not necessarily involve a categorical system of the sort represented by the *DSM*, however. Dimensional systems of diagnosis describe human activity as occurring on a continuum and thereby accommodate the reality that similar behaviors may serve different functions and may have different origins, depending on the individual. Because dimensional systems of diagnosis and the description of behavior in observable, reliable terms point the way to specific interventions without imposing value judgments and permit a more contextual, relational view of human problems, they find favor among social workers (Mattaini & Kirk, 1991).

SOCIAL WORK ASSESSMENT

A concern with diagnosis, or more accurately with assessment, has a long tradition in social work, dating back at least to publication in 1917 of Mary Richmond's *Social Diagnosis*. Richmond identified betterment at the level of the individual rather than the collective as the goal of the case-worker practicing with individuals. Social work assessment of the individual has traditionally focused on the person in interaction with the overarching environment and has reflected a tension between the systemic and the individual approaches.

Richmond declared, "Although the affixing of the correct label is an advance, no such label standing by itself has a practical bearing upon

prognosis and treatment" (quoted in Kutchins & Kirk, 1988, p. 215). Richmond was concerned less with pigeonholing than with the gathering and sifting of information to develop a plan of intervention. In social work assessment, the aim is not to explain apparently aberrant behavior but "totally to apprehend human beings, their inner minds and their feelings, and the way these are expressed in their outward actions and achievements" (Rodwell, 1987, p. 232).

Purpose—whether the objective is understanding or the creation of a clinical formulation or an agenda—largely determines procedure. In any inquiry, the answers produced reflect assumptions (regarding the nature of the problem, for example) implicit in the questions asked. "The ways in which we select, collect, order, and interpret case data are shaped by the perspectives we bring to bear upon them, and the knowledge upon which we draw shapes the way we understand and intervene . . . assessment is both an objective and subjective process" (Meyer, 1992, p. 299).

Social workers have traditionally regarded the assessment process as complex and ongoing, continuing throughout the work, with new hypotheses being tested as new information emerges (McPhatter, 1991). In contrast, the diagnostic system set forth in the *DSM* is often used prior to treatment, with the aim of producing a diagnosis that will dictate interventions. Regardless of the approach selected, a valid instrument cannot be devised until research has determined what information practitioners need (Kirk, Siporin, & Kutchins, 1989; Mattaini & Kirk, 1993).

SOCIAL WORK RESPONSE TO THE DSM

The *DSM* has been credited with increasing the ability of master's-level counselors to conceptualize clients' problems, to plan counseling strategies and referrals, to communicate with other mental health professionals about clients, to access resources, and to establish professional status (Waldo et al., 1993). It has also been called a valuable tool for teaching about mental illness and psychopathology (see Raffoul & Holmes, 1986, and sources cited therein).

Still, social workers required to use the *DSM* on the job have not been uniformly enthusiastic about it. In one survey, clinical social workers

. . . in general . . . rejected the medicalization of mental disorders and thought that *DSM-III* placed medical labels on psychosocial problems. . . many believed that *DSM-III* labels too many problems of childhood as pathological. Half of the respondents thought

that *DSM-III* does not serve the purposes of clinical social work. . . . only a third found *DSM-III* helpful in treatment planning or in determining what medications may be needed. . . . A third believed that *DSM-III* sometimes leads to inappropriate treatment.

Furthermore, many . . . were concerned about the extent to which *DSM-III* inhibits understanding of individual clients. . . . More than 40 percent thought it obscures individual differences and detracts from understanding clients or their problems. More than 70 percent believed that *DSM-III* is of no real help in understanding marital and family problems, . . . a serious limitation because these constitute a significant portion of their caseload. (Kutchins & Kirk, 1988, p. 217)

Survey respondents also expressed concern that the manual gives the "impression that social work's understanding of mental disorder is greater than it is, and [a concern that the manual] allows the overuse of certain diagnoses because of the theoretical orientation of the practitioner" (Kutchins & Kirk, 1988, p. 218). Of survey respondents, 60% asserted that they would not use the *DSM-III* if they were not required to do so (ibid.).

One study of the *DSM-III* found that diagnoses did not correlate with the type of treatment received except that major psychiatric syndromes are associated with the subsequent use of medications (Longabaugh et al., 1986). The absence of a clear-cut, established link between diagnosis and treatment has reinforced a tendency among counselors to regard the latter as separable from the former and more deserving of attention (see Velasquez et al., 1994, p. 1336).

Critics have also charged that the *DSM*, because it views the individual in isolation, fails to address interactional problems and thereby obscures the role played by the family system (Kutchins & Kirk, 1988, p. 219). Although problems within this system may be described by *DSM* V-codes, disorders so labeled are not third-party reimbursable; therefore they are formally relegated to second place in treatment plans. Family therapists have found the scientific paradigm underlying the *DSM* fundamentally different from their own and incompatible with it (Denton, 1990).

Social workers' concerns have been echoed by other mental health professionals. Educators asked about their use of the *DSM-III-R* to train counselors expressed reservations and some ambivalence about integrating the manual fully into their programs. In the words of one survey

respondent, "While our students should learn to use the *DSM-III-R* because it is the official system . . . , we (counselor-educators) should be very careful about giving the message to students that they accept the medical model as a framework for diagnosis and treatment" (Velasquez et al., 1994, p. 1336).

An earlier study (Smith & Kraft, 1983) surveyed APA member psychologists about their opinions of *DSM-III* and other diagnostic approaches and found that 47% of respondents regarded a focus on social-interpersonal forces as the preferred option, followed by nondiagnostic and behavioral analysis, with the *DSM-III* coming in third (p. 781). Fifteen years have passed since publication of this study, and the biological basis of mental disorders is now more fully understood. It remains true today, however, that the manual encompasses not only clusters of symptoms rooted in an individual's biology but also problems in living that are linked to the external environment. Whatever their biological aspects, these difficulties often require psychotherapeutic interventions for lasting results rather than pharmacotherapy alone. Examples include conflictual relationships, phobias, some forms of anxiety, and grief or bereavement issues involving anger, separation, loss, and abandonment.

Such considerations call into question the definition of a disorder as residing exclusively within the individual and suggest the efficacy of the relational approach, traditional in social work, which addresses the fit between the individual and the environment. The importance of this approach is particularly plain when the relevant matrix is understood to comprise not simply a person struggling to survive in the modern world but also a conglomeration of genetic strengths and vulnerabilities (the individual) pitted against a heterogeneous collection of stressors (the environment)—both internal (biological) and external (nonbiological).

Advocates of the *DSM* suggest that social workers should collaborate with other mental health professionals to improve future editions of the *DSM*; still, it may be asked how such a collaboration should proceed, given the fundamental conceptual differences between the medical view of the problem under study and the perspective of the social work profession.

SCIENCE AND SOCIAL WORK: THE NORMATIVE APPROACH AND THE NATURALISTIC

The rise of science in the nineteenth century brought with it greater emphasis on linear cause-and-effect reasoning and a disease model of social ills that was consonant with Social Darwinism (Rodwell, 1987;

Kirk, Siporin, & Kutchins, 1989). The scientific approach reflects various familiar assumptions: there is a single knowable reality; inquiry properly seeks to uncover a lawlike body of knowledge divorced from time and context; identification of such knowledge is desirable to promote prediction and control; knower and known are independent and separable; every event has a real cause that explains it.

As applied to the profession of social work, whose emergence paralleled the rise of science, this normative approach presupposed that the proper goals of treatment were knowable, and could be imposed, by sources outside the client. By locating disorders in the individual, the system precluded calls for change in the external environment. Furthermore, in this scheme of things a problem between people did not constitute a disorder, since disorders had been defined as occurring only within the individual (Denton, 1990). Once social workers had collectively adopted the scientific framework, the profession could claim scientific respectability, with a panoply of analytical tools, scientific principles, and objective descriptions. A diagnostic system was required to permit the development of a treatment typology and differential effective methods of helping.

The normative approach is not, however, the only option. Standing in sharp contrast, the naturalistic perspective involves five fundamental assumptions: there is not one reality but many; inquiry properly seeks not to generalize but to describe the individual case; inquiry is value bound; knower and known interact and are separated by no objectively knowable distance; causes are impossible to distinguish from effects (Rodwell, 1987). Such a perspective harmonizes with social work's traditional values.

Social work often views the problems of a client as functional responses to relational stressors and to the environment and perceives clients as wanting or needing to alter maladaptive behaviors so as to manage their lives more effectively (Carlton, 1989). The focus in psychiatry, however, is on pathology: patients have symptoms that must be eliminated to restore well-being (Raffoul & Holmes, 1986). The behavioral model of mental health treatment familiar to social workers dictates a plan of action that encompasses assessment, intervention, and desired outcome; in contrast, the medical model sets clinical practice in the framework of diagnosis, treatment, and cure.

In short, whereas scientific research characteristically seeks to move from the specific to the general (in pursuit of broadly applicable knowledge, or rules that permit the manipulation of reality), social work practice traditionally moves from the general to the specific (in pursuit of

interpretive understanding). Both approaches are needed. Throughout its history, social work has struggled to see human beings in context while achieving scientific legitimacy.

ETHICAL CONCERNS

Viewed in broad historical context, the use of the *DSM* by social workers presents a variety of ethical concerns. Perhaps foremost among these is the intrusion of the marketplace into clinical practice. Decisions regarding the nature and quality of care that social workers provide to their clients, once driven by assessment and by clients' expressed needs, today increasingly reflect the dictates of insurance companies whose medicalization of the mental health field confers supreme authority upon physicians.

Although physicians have long enjoyed considerable prestige in our society, psychiatrists have not historically been on equal footing with their medical colleagues, in part because scientific knowledge about disorders of the brain has lagged well behind that amassed about illnesses principally associated with other parts of the body. A desire for parity with medical professionals generally has been a powerful force motivating psychiatrists, psychologists, and social workers in their efforts to determine how clients' problems are defined (Valenstein, 1986; Carlton, 1989; Oppenheim, 1991; Dawes, 1994). The *DSM*, then, is noteworthy not simply as a diagnostic method but also as a statement endorsed by the medical profession.

Today any group of mental health treatment providers that rejects the methodology and outlook of the *DSM* risks being excluded from power, here understood to be the coverage of services by third-party payers. Lack of access to such coverage places practitioners at a serious economic disadvantage (Denton, 1990, p. 120) and makes financial considerations a major determinant of the type—and quality—of care available.

The *DSM* may invite or encourage deliberate misdiagnosis in response to financial concerns in the case of particular individuals. A clinician may overdiagnose with the aim of helping the client secure insurance reimbursement; conversely, a clinician who worries about the label's long-term stigmatizing effects once it has been recorded in a client's file may deliberately underdiagnose (Kutchins & Kirk, 1987; Kirk & Kutchins, 1988).

Still other ethical problems may inhere in the requirement that social workers hew to a medical definition of their task. Is it appropriate for all mental health professionals to be required to use a manual that is the property of one professional organization (Kutchins & Kirk, 1989a)? Does use

of the nosology set forth in the *DSM* require social workers to believe that the problem being treated is a disorder as defined by the manual—and are reimbursement and treatment properly denied if it is not? Are clients—to whom social workers owe their primary duty—well served when mental health professionals privilege the psychiatric viewpoint over others?

As two thoughtful social workers have asked:

What are the long-term consequences of defining increasing numbers of human problems as “mental disorders,” or of adopting a categorical classification that suggests that people either have a “disorder” or are normal, of minimizing the influence of social context on behavior, of allowing increasing numbers of behaviors to fall under the professional domain of medicine, or of participating in the design of a system of reimbursement that impels many mental health providers to act dishonestly in completing insurance forms? (Kutchins & Kirk, 1989b, p. 188)

Such questions are of course framed by larger considerations. How should we properly define problems that are eligible for reimbursement? Finally, how large a role should medical insurance play in the maintenance of an individual's health and well-being?

CONCLUSION

The *DSM* is likely for the foreseeable future to remain a tool that must be used by social workers employed in mental health settings. Social workers familiar with its terminology and methodology will be able to participate more fully in dialogue with medical practitioners than they otherwise could. In addition, *DSM* diagnostic categories afford the clinician ready access to the latest medical research in the databases. Finally, the *DSM* diagnostic criteria may assist social workers who are monitoring the side effects of medication.

Playing as it does a pivotal role in the reimbursement of social work services, the *DSM* invites mental health professionals to ask a threshold question about the nature of the problem being treated: whose definition should determine treatment, that of the psychiatrists or that of the practitioner's profession? Surely the client's best interests should determine the answer.

Diagnostic criteria afford a starting point for dialogue between the client and the clinician. Discussion of them can promote self-monitoring,

the identification of treatment issues, and the worker's understanding of the client. By coming to terms with current medical thinking, the client can assume greater responsibility for himself or herself and can become a more informed consumer of mental health care. The *DSM*, in short, can be used to empower clients.

However imperfect the manual may currently be as a diagnostic guide, the pathophysiology of psychiatric disorders will eventually be understood. The criteria set forth in future editions of the *DSM* will presumably meet increasingly rigorous standards of validity and reliability. As scientific knowledge advances and as social workers become better educated regarding the neurobiological basis of their clients' problems, social work values and forms of assessment will continue to play a role in the treatment of the mentally ill. The fit between the person and the environment will remain an important focus of attention. The utility of a medical “cure” in any specific case will depend not just on its efficacy but also on the personal priorities of the client—the context of each individual's life.

Social workers have traditionally sought to avoid reductionism and the pure cause-and-effect analysis of complex human problems. For the present, the *DSM* must be regarded as one tool of many, offering only one point of view. Providers of mental health care can continue to avail themselves of this resource while promoting awareness of its limitations and also drawing on the perspectives of other disciplines. Indeed only by doing so can social workers serve their clients to the full and thereby discharge their primary professional responsibility.

NOTES

1. According to the *DSM-IV* definition, a mental disorder is “a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g., political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above” (American Psychiatric Association, 1994, pp. xxi–xxii).
2. The diagnostic criteria employ language that presupposes that clinicians will agree not only about what they are seeing but about the degree to which it deviates from the norm; the criteria for 301.83, Borderline Personality Disorder, for example,

presume that the words "frantic," "real or imagined," "unstable," "intense," "chronic," and "inappropriate" will be applied in precisely the same ways by all clinicians performing an assessment. Interestingly, a member of the DSM-IV Task Force expressed this viewpoint in writing about stressors enumerated on axis IV: "To avoid ratings of individuals' idiosyncratic vulnerabilities, clinicians should rate the severity of the stressors according to how they judge an 'average' person would experience them. Thus, even though a particular individual reacted catastrophically to a change in a work schedule, the stressor itself would only be rated as 'mild,' because that is how an average person would experience it" (Williams, 1981, p. 104).

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