The Evolution of Psychopathology in Social Work

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Abstract

The term "psychopathology" dates back to the ancient civilization of Hippocrates and Aristotle. Yet, it did not gain wide acceptance in practice until advocates like Freud, Kraepelin, and Meyer applied it to practice with clients. The acceptance of psychopathology in practice has been slow and tumultuous. The National Association of Social Workers stated that a vast majority of providers of mental health services in the United States are social workers. For mental health practice, the most widely used assessment system has been and is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health, DSM. About 20 percent of Americans have experienced psychiatric disorders, and this figure is expected to be increasing. Despite one's career path within the field of social work, practitioners are more than likely going to encounter clients with a mental illness. Thus, those who work with the mentally will need to learn how to decipher the DSM format.

Keywords: Psychopathology; Social work practice; Hippocrates; Aristotle

Introduction

Celebrities like Lindsay Lohan, chronic rehab visitor and inmate, and Catherine Zeta-Jones, recent convert to the diagnosis of Bipolar-II on the cover of People magazine, shine the spotlight on psychopathology with news of their addictions, drug use, alcohol abuse, eating disorders, and mental illnesses. Books, like Brook Shields' *Down Came the Rain: My journey through postpartum depression* and Ruth Graham in every pew sits a broken heart, are dedicated to personal accounts of struggles with schizophrenia, depression, phobias, and panic attacks. Films such as *A Beautiful Mind* and *As Good As It Gets* portray aspects of psychopathology with a varying degree of accuracy. And then, there are the tragic news stories of mothers who kill their children and wherein depression, schizophrenia, or post-partum problems may be implied. It is difficult to escape public awareness of mental health topics and problems that are concerns in psychopathology, particularly those of celebrities living with the problems who receive widespread, international attention [1]. About 20 percent of Americans have experienced psychiatric disorders, and this figure is expected to be increasing [2].

Despite social workers' varied career paths, all practitioners are likely to encounter clients with mental illnesses. The National Association of Social Workers points out that a vast majority of

providers of mental health services in the United States are social workers [3]. For mental health practice, the most widely used assessment system has been and is the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Health, DSM [4]. Thus, those who work with the mentally ill need to learn how to decipher the DSM format and appropriately diagnose clients. The purpose of this paper is to help social workers understand the history of psychopathology and its slow evolution and integration into practice.

A Historical Perspective of Psychopathology

Definition of psychopathology

The Social Work Dictionary defines psychopathology "as the study of the nature of mental, cognitive, or behavioral disorders, including causes, symptoms, effects on the subject, and the psychosocial circumstances in which the dysfunction occurs" [4]. Maxmen and Ward defined psychopathology "as the

manifestations of mental disorders" [5]. It involves impairments, deviance, and distress, but not all impairments, deviance and distress are psychopathology. Conceptions of psychopathology and the various categories of psychopathology are not mappings of psychological facts about people. Instead, they are social artifacts that serve the same sociocultural goals as do conceptions of race, gender, social class, and sexual orientation—those maintaining and expanding the power of certain individuals and institutions and maintaining social order, as defined by those in power [6]. Thus, the debate over the definition of psychopathology is not to search for "truth," but to define what and whom society views as normal and abnormal.

Psychopathology remains today, however, a relatively young science. Moreover, many current techniques and theories have long histories that connect current thinking to preexisting beliefs and systems of thought. Many are intertwined in chance associations, primitive customs, and quasi-tribal quests [7]. For example, Goldman defined "psychopathology as the study of mental disorder and abnormal thoughts, feelings, and behavior. Clinical psychiatry is thus concerned with two related processes: (1) Diagnosing mental disorder and (2) Assessing psychiatric factors in health and illness". The process of psychosocial formulation parallels the diagnostic process in medicine, Psychiatry, and social work practice [8]. Its goal is to enable the clinician to understand each patient individually. Diagnosis is simple. Diagnostic systems, generally called classifications, are lists of terms for conventionally accepted concepts that are used to describe psychopathology.

Critics like Thomas Szsaz argue that because the line between psychopathology and normality may be hazy, psychopathology is a myth [9]. For example, day and night exist, even though they may be difficult to distinguish at dusk. Similarly, psychopathology is no less real for its relativity. The definition of a mental disorder in the DSM-V does not suggest that there are sharp distinctions between psychopathology and normality or between different mental disorders. According to DSM-V, mental disorders must produce clinically significant impairment or distress in one's personal, social, or occupational life [5]. Psychopathology's routine use in practice unfolded over time in conjunction with key clinicians' influence.

Evolution of psychopathology and the DSM

The earliest treatment of mental disorders of which there is any knowledge was that practiced by Stone Age cave dwellers some half a million years ago. However, the earliest explanation, of what is referred to as psychopathology, involved the possession by evil spirits and demons [1]. Clinical psychologists often use psychopathology as a synonym for abnormal behavior. Many believed, even as late as the sixteenth and seventeenth centuries that the bizarre behavior associated with mental illness could only be an act of the devil. To remedy this, individuals suffering from mental illness were tortured in an attempt to drive out the demon [10]. Most people are familiar with the witch trials where many women were brutally murdered due to a false belief of possession. When the torturous methods failed to return the

person to sanity, they were typically deemed eternally possessed and were executed.

By the eighteenth century, mental illness was perceived differently. During this time, "madness" began to be seen as an illness beyond the control of the person rather than the act of a demon [1,10]. As a result, thousands of people were confined to dungeons of daily torture and released to asylums where medical forms of treatment began to be investigated. For example, today, the medical model continues to be a driving force in the diagnosing and treating of psychopathology issues. Although research has shown the powerful effects that psychology has on a person's behavior, emotion, and cognitions, mental illnesses have classifications and their effects have been examined on individuals and society [10]. Therefore, the DSM is based on research and organized according to diagnostic criteria.

At the end of the 19th century in Germany, Emil Kraepelin developed a system of identifying diseases by focusing on certain groups of signs and tracking their eventual outcomes as a method of determining disease entities. The development of psychiatric nosology in the United States has been shaped primarily by external demands and broad social forces, rather than by the desires or felt needs of practicing clinicians [7,9,11]. The earliest classification system of mental disorders that was developed by the federal government to use for the United States Census. The 1840 census played a predominant role in psychiatric nosology during the 19th century [9]. At the time, there was only 1 category: Idiocy, which included insanity. By 1880, there were seven categories: mania, melancholia, monomania, paresis, dementia, dipsomania, and epilepsy. The categories were broad, and psychiatric treatment at the time was nonspecific. The struggles to develop a systematic nomenclature, from the earliest decades of the 19th century were motivated by administrative and governmental needs, not by demands from practitioners. The experience of psychiatrists during World War II was responsible for the first major change in psychiatric nosology. It was embodied in the Diagnostic and Statistical Manual: Mental Diseases, now commonly referred to as the DSM-I.

The American Psychiatric Association (APA) first published the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. The DSM-I was the first official standardized psychiatric nomenclature for the United States [6,12-14]. Additionally, it was the first official manual of mental disorders to focus on clinical utility [15]. DSM-I contained a glossary of descriptions of the diagnostic categories; however, the diagnoses were loosely defined and emphasized psychological etiologies in the terminology. A purely psychological approach pervaded the DSM-I [6]. It attempted to blend the psychological with the biological and to provide for the practitioner a unified approach known as the psychobiological point of view [12,15]. The use of the term "reaction" throughout DSM-I reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors (DSM-IV-TR, 2000). As innovative as it was, still, it did not incorporate the World Health Organization's International Classification of Diseases (ICD).

The purpose in writing the DSM-II, which was published in 1968, was to rectify the DSM-I's failure to conform to the ICD [5]. This was necessary because of an international agreement to use the ICD as the official reporting system for all illnesses. Unlike its predecessor, the DSM-II encouraged rather than discouraged the use of multiple diagnoses for a single patient, the DSM-I term reaction was dropped, and it did not reflect a particular point of view (9, p: 27; 15). Rather, it attempted to frame the diagnostic categories in a more scientific way. A British psychiatrist, Stengel, can be credited with having inspired many of the recent advances in methodology, especially the need for explicit definitions as a means of promoting reliable clinical diagnoses [15]. However, DSM-II did not follow Stengel's recommendations to any degrees and the DSM-II was similar to DSM-I, but eliminated the term reaction [15]. Many professionals criticized both the DSM-I and DSM-II for being unscientific and for encouraging negative labeling.

Meanwhile, Vietnam veterans were demonstrating for the adoption of the diagnosis of post-traumatic stress disorder so that they could qualify for psychiatric benefits [14]. They finally succeeded with the publication of the DSM-III. The irony was that in the very act of remedying two genuine grievances, the APA confirmed the charges of political influence on the formulation of diagnosis. DSM-III, which was published in 1980, tried to calm the controversy by claiming to be unbiased and more scientific. This edition introduced a number of important methodological innovations including explicit diagnostic criteria, a multi-axial system, and a descriptive approach that attempted to be neutral with respect to theories of etiology [14,15]. Even though many of the earlier problems still persisted, these problems were overshadowed by an increasing demand for the DSM-III diagnoses being required for clients to qualify for reimbursement from private insurance companies or from governmental programs [12]. The major complaint against this edition of the DSM was that the information was not well grounded in evidenced-based practice.

Critics like Thomas Szasz, who claimed that mental illness is a myth, promoted the embracing of a diagnostic model from medicine where diagnosis is the keystone of medical practice and clinical research [8,9]. Instead of the psychosocial and psychodynamic models of psychopathology that was reflected in the DSM-III. With the publication of this DSM edition in 1980, psychiatric nosology underwent a radical shift, reflecting the significant changes that psychiatry as a field was undergoing in the 1960s and 1970 [13]. Changes in criteria that have occurred with the two revisions since DSM-III have been based largely on field-testing of diagnostic criteria for validity, reliability, and stability [5]. Each diagnostic manual is a work in progress that incorporates changes based on new information. Although the DSM-III-R had numerous small changes, it remained completely faithful to the DSM-III paradigm of employing descriptive operational criteria for defining categorical disorders [13].

After the publication of the DSM-III-R, the APA announced the edition had been a mistake and was working on the DSM-IV for publication [9]. It was said that the DSM-IV is easier to use than the older ones, but the claim is difficult to justify. The volume is more than 900 pages, 50% longer than the DSM-III-R, yet it adds only 13 new diagnoses, and eliminates eight old ones. The instructions are often excessively complicated. In 2000, the APA published the text revision of the DSM-IV, which updated the prose sections of the manual but left the diagnostic criteria and number of diagnoses the same [7]. In addition, the American Psychiatric Association in 2000 established committees to initiate preliminary studies regarding changes proposed for the DSM-V, publication of which is planned for 2013.

Release of the DSM-V at the APA's Annual Meeting in May 2013 marked the end of more than a decade's journey in revising the criteria for the diagnosis and classification of mental disorders (APA, 2013 http://www.dsm5.org/Pages/Default.aspx).

The DSM has evolved from a brief, poorly researched 134-page manual to a 943-page elaborate diagnostic manual with "diagnostic criteria" and a multi assessment format based on extensive literature reviews, 12 field trails with over 70 sites, and a five volume textbook set outlining 150 literature reviews, data, and field trial results [15]. Also, the DSM has ensured that each revision is carefully linked to the International Classification of Diseases (ICD) to ease linkages between two typologies [3]. This linkage is very useful for insurance reimbursement coding. Today, the DSM is similar to the ICD in terms of diagnostic codes and the billing categories that result; however, this was not always the case.

Advocates of psychopathology

Three of perhaps the most influential advocates for the integration of psychopathology into clinical practice are Sigmund Freud, Emil Kraepelin, and Adolf Meyer.

Freud: Sigmund Freud, the father of psychoanalysis, has influenced not only psychiatry, but also the course of modern thought about human psychology and the role of child development. His theories about mental disorders are psychodynamic and developmental. Freud was initially an outsider and rejected by the medical establishment of Vienna. Eventually, his theories came to dominate psychological treatment in many countries. Nowhere was his influence greater than in the United States, a country he detested and refused to visit after his initial sojourn in 1911 to give the famous Clark lectures [9]. Psychoanalytic ideas generated tremendous excitement because of its unique approach to the understanding of the whole person and subsequent treatment decisions.

Kraepelin: Freud's dynamic theories of substructures of mental disorders have been contrasted with Emil Kraepelin's (1856-1926) approach, which is primarily descriptive Kraepelin is virtually unknown even to most of the mental health professionals. He was a respected professor and a tireless researcher in Germany. He established one of the first psychiatric laboratories and was the author of several textbooks. Both his books, *Psychiatry and Introduction to Clinical Psychiatry*, went through many editions during his lifetime. Whereas, Freud was primarily concerned with the etiological dynamics of mental disorders, Kraepelin

throughout his career attempted to classify, categorize, and describe psychiatric disorders as discrete entities. According to Hoffman [11], "Freud did not deny the importance of organic factors, but rather attempted to bring in the psychological dimension". Kraepelin's descriptive efforts are the basis for the current approach to the identification of mental disorders. Although his books are now outdated, and seldom ready by his adherents, it is his approach that has come to dominate modern psychiatry and to eclipse Freud's work, if not his fame [9].

Meyer: Adolf Meyer (1866-1950) introduced the concept of a "constitutionally inferior psychopathic" type into American literature at the turn of the century. Meyer sought to separate psychopathic from psychoneurotic disorders. He was convinced that the etiology of the neuroses was primarily psychogenic, that is, colored less by inherent physical defects or by constitutional inferiorities. As early as 1910, Meyer espoused the view that the only way to derive a true understanding of patients would be by studying individuals' total reaction to their organic, psychological, and social experiences. Although Meyer was the prominent psychiatrist to introduce Kraepelinian system to the United States, he believed that these disorders were not disease entities but "psychobiological reactions" to environmental stress. His psychobiological approach to schizophrenia was the most systematic recognition of his interactive and progressive view of the nature of pathogenesis.

Each of these men played an important role in the history of psychopathology. It would seem as though they all played important roles in the development of modern psychiatry and categorical system used today to diagnosis mental illnesses. Even though they did not always agree or follow the same view, without their part, which knows where psychopathology is today. Most importantly, they became advocates for the acceptance of psychopathology and the Kraepelin approach that has come to dominate modern psychiatry.

Psychopathology and social work practice

The use of the *Diagnostic and Statistical Manual of Mental Disorders* as a teaching tool for social workers to understand mental illness has been debated for many years [16]. The general consensus is that social workers need to be familiar with the classification system, but not actively use it in clinical practice. In 1999, the Surgeon General's Report on Mental Illness defined Mental Health as the "Successful performance of mental function, resulting in productive activities, fulfilling relationships with others and the ability to adapt to change and successfully cope with adversity" [16]. Using such a definition, social work is in a unique position to utilize this strengths-based perspective when assessing and diagnosing clients.

Numerous authors maintain that specific emphasis on the psychiatric taxonomic perspective in social work education is insufficient in order to understand the complexity of psychopathology from a social work point of view [14,17-19]. They argue that the DSM neglects, and even negates, such social work tenets as:

"Systems theory emphasizing the crucial role of families, small groups and communities; a growth and development model of human behavior; the individualization of the client; a sensitivity and commitment to multicultural diversity; the emphasis on client abilities and strengths; concerns about distributive justice; and the focus on the client empowerment model for intervention" [14].

Contemporary social work training can be differentiated from training of other mental health professionals by its emphasis on assessing the whole person.

As a result, the social worker must understand what factors may have caused or contributed to the development of a mental disorder and what needs to be modified in the person and/or environment to improve coping and mastery [16]. Thus, a philosophical approach to education about mental illness reveals the more inclusive person-in-environment approach, emphasizing bio psychosocial assessment and holistic perspective. This perspective enables social work educators to frame the DSM as an adjunct to social work education about mental illness and the human condition, rather than as the foundation.

Social workers routinely provide diagnoses for clients as an expected clinical skill within the context of many managed behavioral health care practice environments. Employers, licensing agencies, and insurance companies expect clinical social workers to know how to formally assess and diagnose mental disorders [3]. However, social work students often only receive one class in psychopathology or some variation that introduces the student to assessments in mental health and addictions. The classes highlight the DSM-V-TRDSM-V as a useful tool of assessment. The training is essential as, once they graduate, many social workers work within a mental health agency. In addition, the Association of Social Work Boards includes DSM questions specifically to the licensure exam that is required in nearly every state in the United States. Thus, knowledge of how to correctly use DSM, despite the criticisms, is essential to most social workers [3]. It is imperative that social work educators emphasize use of the DSM, in field education placements and clinical supervision to help students and recent graduates to appropriately apply concepts from the DSM in practice.

Managed care has transformed the landscape of mental health practice, and it is becoming increasingly necessary to conduct the kind of assessment that provides accurate information about a person's complex mental health symptoms. The need for an inter-professional collaboration is becoming increasingly apparent as professionals are pressed to "justify themselves by advocates and by the public-at-large." Social work practice in the millennium has become more complicated and underscores the growing need for inter-professional collaboration, which draws upon the knowledge from different disciplines and professionals. Merging the expertise and knowledge from different disciplines maximizes the creativity needed for fully understanding the symptoms experienced by those who are struggling with mental illness [2].

One of the problems in using the manual is that one might come away from it questioning how the diagnostic criteria presented translate into real-life clients seen in practice. It is not only important for social workers to know how to assess individuals

effectively, but also, how to develop an intervention plan that addresses clients' needs [2]. Case studies like the following are valuable in assisting students to apply and develop their skills for assessing individuals and developing intervention plans to help address the client's needs and strengths using psychopathology and the DSM.

Application of psychopathology: the Rogers family case study

The Rogers' Family was referred by the court to obtain a family assessment to determine why the nine-year-old daughter is pulling out her eyelashes and what can be done to stop it. Described in Appendix 1, the family cannot afford to pay; therefore, this assessment will be completed pro bono referred by an "attorney-friend." **Table 1**, depicting the case timeline, shows that the couple has been married for 11 years and separated for the last three months due to the husband's refusal to end an affair. She moved out taking the daughter and began divorce proceedings. This may have been the first time that the wife disagreed with the husband and set a firm limit with him. When the wife returned to the home to gather her belongings, the husband severely beat her. The daughter began pulling out her eyelashes although it is unclear exactly when this behavior began. As a result, the court ordered a family assessment.

The social worker met with the family eight times, once with the mother and father individually, once with the couple, once with the daughter and each parent, and three individual sessions with the daughter alone. The following three sections describe the assessment and diagnosis of each family member. The clinical impressions section synthesizes the assessment and predicts the prognosis of individual and family treatment.

Assessment

Tanya Rogers (Wife-Mother)

The following case study is part of the curriculum at The School of Social Work (Unpublished Case Study, 2012). After an individual interview, the social worker collected information to assess and diagnose Tanya Rogers and to create a working hypothesis for the family. As shown in Appendix 2 and below, Tanya appears to meet the criteria for Posttraumatic Stress Disorder, Chronic.

Assessment multi-axial DSM-IV: Tanya Rogers Assessment Multi-axial DSM-IV, the Diagnosis Is As Follows:

Axis 1 309.81
Posttraumatic Stress Disorder Chronic, Chronic
Axis II V71.09
Axis III None

Axis IV Problems with primary support group; problems related to social environment; Problems related to interaction with the legal system/crime

Axis V GAF=56

Tanya Rogers's diagnosis of PTSD Disorder was given due to diagnostic criteria being met **(Table 2)**.

A. The person has been exposed to a traumatic event in which both of the following were present: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. Tanya experienced an event that involved an actual threat and serious injury to her and physical integrity to self-due to physical incident from recently separated husband. (2) The person's response involved intense fear, helplessness, or horror. Her response since incident has been intense fear as noted by when Tanya jumped during session as car squealed and horror can be evident based on this being the first time her husband of 11 years has become physically abusive to her.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways: (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Tanya discusses how when she tries to talk about it she gets freaked out and when she recalls the event she gets very scared. (2) Recurrent distressing dreams of the event. Tanya does not seem to exhibit this symptom. (3) Acting or feelings as if the traumatic events were recurring. Tanya states it feels like it is happening all over again, but tries to push it out of her head; when she recalls the event she becomes very scared again, and can't think straight. (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Tanya does not seem to exhibit this symptom. (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. Tanya seems to exhibit this symptom based on anxious reaction when car squeals.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three (or more) of the following: (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma. Tanya states how she tries to "push it out of her head," in discussing the "incident." (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma. Tanya does not seem to exhibit this symptom. (3) Inability to recall an important aspect of the trauma. Tanya discussed how she really tries hard to not think about it (incident). (4) Markedly diminished interest or participation in

Table 1: Critical event timeline for Rogers family.

32 years ago	Tanya born
11 years ago	Tanya+Tom Rogers married
9 years ago	Trish Rogers born
3 months ago	Tanya+Tom Rogers separated (Tom refused to end affair. First time Tanya disagreed with Tom and threatened divorce)
Next day	Tanya moved out with Trish
1 week later	Tom beat Tanya "very badly" when she returned to house to collect her things
	Rogers family referred by judge for assessment to determine why Trish is pulling out hair and what needs to happen to stop it
Meeting 1	Tanya Rogers
Meeting 2	Tom Rogers
Meeting 3	Tanya+Tom Rogers
Meeting 4	Tanya+Trish Rogers
Meeting 5	Tom+Trish Rogers
Meetings 6, 7, 8	Trish Rogers

Table 2: Tanya (Wife-Mother) DSM and PDM diagnoses.

DSM PTSD Disorder was given due to diagnostic criteria being met:	PDM Symptom Patterns: The Subjective Experience (S-Axis)
A. The person has been exposed to a traumatic event in which both of the following were present:	The S-Axis of the PDM discusses S302.1 Psychic Trauma and Posttraumatic Stress Disorders under the category of Anxiety Disorders.
(1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.	Affect states related to traumatization include unmanageably overwhelming feeling reactions (including rage, terror, and shame about having been traumatized).
(2) The person's response involved intense fear, helplessness, or horror.	
B. The traumatic event is persistently re-experienced in one (or more) of the following ways: (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. (2) Recurrent distressing dreams of the event. (3) Acting or feelings as if the traumatic event was recurring. (4) Intense psychological distress at exposure to internal or external cues that symbolize or (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.	Cognitive patterns that seem unique to posttraumatic stress disorders are flashbacks and recurrent nightmares. Somatic states characteristic of posttraumatic stress disorders include irritability, sleep disturbances, and efforts at self-medication through substance abuse. Relationship patterns may include changes in relating to others, based on decreased trust and increased insecurity, and states of numbness, withdrawal, chronic rage, and guilt.
C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness, as indicated by three (or more) of the following: (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma. Resemble an aspect of the traumatic event. (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma. (3) Inability to recall an important aspect of the trauma. (4) Markedly diminished interest or participation in significant activities. (5) Feeling of detachment or estrangement from others. (6) Restricted range of affect. (7) Sense of foreshortened future.	

significant activities. Tanya seems to want have a more fulfilling role as a mother based on her saying, "I really want to do better for her (daughter)." (5) Feeling of detachment or estrangement from others. When it comes to her daughter, Tanya discussed half the time feeling impatient and half the time feeling like she does not pay enough attention to her (daughter). (6) Restricted range of affect. Tanya seems to reflect a "one dimensional" aspect of her affect by displaying a sense of saddened state of emotion, but not a multiple range of emotions such as happy, sad, excited, etc. (7) Sense of foreshortened future. Tanya does not seem to exhibit this symptom at this time.

D. Persistent symptoms of increased arousal as indicated by two (or more) of the following: (1) Difficulty falling or staying asleep. Tanya states, "Since all this has happened I just can't stay asleep." (2) Irritability or outbursts of anger. Tanya states having headaches which may be due to lack of sleep or recurrent thoughts of incident; she also mentions feeling horrible about not being the best mother and feeling inpatient with her daughter. (3) Difficulty concentrating. Tanya states she feels that half the time she is inpatient "...and the other half I'm just not paying close enough attention to her (daughter)." (4) Hyper vigilance. Tanya does not seem to exhibit this symptom but states being "...on edge since the incident." (5) Exaggerated startle response. Tanya jumps as a car squeals outside; this seems to denote a fair amount of anxiety.

E. Duration of the disturbance is more than 1 month: Tanya has been separated from her husband for 3 months. The domestic incident occurred one week after Tanya and her daughter Trish left the home. It seems reasonable that the symptoms have being on-going for 3 months or more.

F. The disturbance causes clinically significant distress or impairment in social, occupation, or other important area of functioning. Tanya is not talking about the incident to anyone (friends or family) due to getting freaked out when she talks about it and feels ashamed that this incident could happen to her. Also, it seems to be causing relationship problems with her daughter due to a lack of interaction and causing impairment in her functioning role of a mother.

Disorders considered being assessed for Tanya: R/O Acute Stress Disorder due to duration of symptoms being more than 1 month based on upon separation from husband for 3 months, and physical incident occurring one week after leaving husband.

- R/O Major Depressive Disorder due to not getting a full view of a loss of once pleasurable activities as these were not discussed by Tanya, but did seem depressed in the way she described her recent physical incident and how her role with husband by feeling "ashamed" for trying to spend her time making him happy and hating to seem him angry. She also mentioned sleep disturbances, feelings of guilt/shame, and seemed to suggest lack of feeling anything, which can account for Major Depression. However, there was never a sense of loss of appetite tired or decreased energy most of the time or a statement about suicidal ideation, which is almost, always presents according to Gray and Zide [2].

- R/O Adjustment Disorder due to the prevailing physical incident being more than just an adjustment to a stressor but more of a traumatic event.

- R/O any Personality Disorder on Axis II such as Dependent due to not knowing her full personality as much of her complaints, symptoms, affect come from a psycho-stressor (i.e., physical abuse incident).

PDM diagnosis: Tanya Rogers S-Axis of the PDM discusses S302.1 Psychic Trauma and Posttraumatic Stress Disorders under the category of Anxiety Disorders.

Affect states related to traumatization include unmanageably overwhelming feeling reactions (including rage, terror, and shame about having been traumatized). Tanya seems to experience a "shameful" feeling about being traumatized from the physical incident.

Cognitive patterns that seem unique to posttraumatic stress disorders are flashbacks and recurrent nightmares. The thinking of traumatized individuals may include the following which seems to include Tanya's cognitive thoughts: thinking about traumatic events, including the helpless sense of being able to think of nothing else ("...she really tries very hard not about it."), and developing a theory of how they could have avoided the trauma ("...she spends a lot of time wondering if she could have done something different to avoid the beating.").

Somatic states characteristic of posttraumatic stress disorders include irritability, sleep disturbances, and efforts at self-medication through substance abuse. Tanya has elaborated on not getting enough sleep and having difficulty sleeping, and states having headaches which may be due to lack of sleep and may be a sign of irritability. However, no sign of self-medication resulting from substance abuse is seen at this time.

Relationship patterns may include changes in relating to others, based on decreased trust and increased insecurity, and states of numbness, withdrawal, chronic rage, and guilt. Tanya stated her feelings of numbness and guilt. Also a feeling of withdrawal may be present as discussing how her relationship with her daughter Trish seems to be struggling at school, but Tanya does not seem to know how to help her. In this section of the PDM it states, "Psychic trauma often increases sadomasochistic modes of interacting, leading to derailment of dialogue, and ruptures in connectedness." This may be taking place as evident when Trish tries to build up her mother and engage her mother in the conjoint drawing during the session.

Overall the S-Axis for Psychic Trauma and Posttraumatic Stress Disorders in regards to affect and somatic states, as well as cognitive and relationship patterns seem to be defined similarly to Tanya's symptom patterns. She seems to have a close, relationship with her daughter Trish but this may be becoming lessened due to Tanya's overall reactions of guilt, anxiety, sleep disturbances, headaches, and a general focus on trying to rethink how she could have behaved different due to this traumatizing physical abuse incident involving her husband.

PDM (Personality Patterns and Disorders) P-axis: Tanya Rogers P-Axis of the PDM discusses under the subheading, "Differential Diagnosis of Personality Disorders As A Class" in understanding personality and disorders how "...there is no hard-and-fast dividing line between personality type and personality disorder-human functioning falls on a continuum....One can have, for example, an obsessive personality without having an obsessive personality disorder." This is a helpful guide in understanding Tanya's situation of being given the diagnosis of an anxiety disorder, yet her personality does necessarily fit the category of "Anxious Personality Disorder" of the P-Axis. Based on the description of the P-Axis, Tanya seems to be more on the neurotic end of the spectrum in her ability to have perspective on her problem and how she would like to change. She seems to be fixed on one aspect of her relationship (husband), not a multitude of relationships, and wanting what is best for her daughter as well. Tanya most likely would fit the category of P107 (Depressive Personality Disorder). This class of personality seems to be a more common personality structure encountered by clinicians and often does not signify the person has a single depressive episode as noted by the PDM. This class focuses on two subtypes of symptomatic depression: introjective and anaclitic. Anaclitic seems to represent Tanya as it is characterized by shame, high activity to loss and rejection, and vague feelings of inadequacy and emptiness. Tanya describes her relationship with her husband of 11 years as almost a one-sided relationship in how she spent much of her time trying to please his well-being by getting a part-time job despite her desire to return to school and obtain a full-time career. Another decision made by Tanya's husband was to fulfill a "caretaker" role by staying at home and to take care of the house and their daughter, and Tanya believed that if she did not respond to these decisions and roles in the correct way, her husband would discontinue this marriage. Currently, she has feelings of guilt associated with the physical incident and seems to convey these vague feelings of emptiness. She is at a loss as she has been separated from her primary support system, which shows evidence of anaclitic depression.

Contributing constitutional-maturational patterns, possible genetic predisposition to depression: It is unknown whether or not Tanya may have a genetic predisposition to depression but a further in-depth look at family medical history would be important to explore.

Central tension/preoccupation, Goodness/badness or aloneness/relatedness of self: Tanya elicits a moral anxiety in regards to accepting behavior from her husband, but could not accept the situation of the affair, as it was usually her consistent manner to accept other situations despite her non-approval. She feels she has to stand up for something that was not right, yet there seems to be this overarching isolated feeling of aloneness as noted by daughter's nonverbal behavior of trying to "comfort" her mother.

Central affects sadness, guilt, shame. Tanya exhibits feelings of guilt and shame for the physical incident in that "...something like this could happen to her." Tanya may be exhibiting guilt over how she has always played this "passive" role of only being there for her husband and not being able to stand up for her own well-being.

Characteristic pathogenic belief about self: There is something essentially bad or incomplete about me. Difficult to see this

relating to Tanya's disposition, but there is this feeling of "... nothing seems real..." as if to convey an incompleteness about who Tanya is now that she is separated from her husband and now her role as a mother and wife, is now just a mother, and the unknowing of her role outside of a caretaker.

Characteristic pathogenic belief about others: People who really get to know me will reject me. This too is difficult to tell her feelings toward others, but there seems to be a lack of connection with daughter and could possibly relate to a rejected mindset that her daughter is upset with her for this separation from her father. Therefore Tanya may be thinking her daughter rejects her for standing up for herself and leaving her husband due to this affair, rather than thinking about her daughter's well-being and keeping the family together.

Central ways of defending-Introjection, reversal, idealization of others, and devaluation of self: Tanya may be showing introjections of dislike for herself in her decision to leave husband and feeling as if she could have avoided this physical confrontation. She also may be feeling a devaluation of self as she seems to be unsure of whom she is based on her somatic descriptions of numbness and having a blanket being thrown over her. The reversal and idealization of others does not seem relevant at this time in addressing Tanya's disposition.

Tom Rogers (Husband-Father)

DSM diagnosis: Tom rogers assessment multi-axial Dsm diagnosis is as follows:

Axis I	799.9
Axis II	301.81 Narcissistic Personality Disorder
Axis III	None

Axis IV   Problems with primary support group, problems related to interaction with the legal system/crime

Axis V GAF=70

Tom Rogers' diagnosis of an Axis I disorder is deferred, pending the gathering of additional information. Therefore, the diagnosis of Narcissistic Personality Disorder was given due to the following criteria being met: A pervasive patter of grandiosity (no fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

(1) Has a grandiose sense of self-importance. Tom seems insistent to state how this is the only child he is going to have; asking why he cannot know what Trish said about him; he is not at fault for Trish's behavior of pulling out eyelashes as the court makes it seem to be.

(2) Is preoccupied with fantasies of unlimited success, power, brilliances beauty, or ideal love. Tom seems to have an ideal love for himself as well as relating this fantasy of how others seem to really admire.

(3) Believes that he is "special" and unique and can only be understood by, or should associate with, other special or high-status people. Tom does not seem to exhibit this symptom.

(4) Requires excessive admiration. Tom discussing how all the children and their parents love him as the local basketball coach; talking about how good he is with children; all the things that make him a good father.

(5) Has a sense of entitlement. Tom wanting to know why he could not know what his daughter said about him.

(6) Is interpersonally exploitative. Tom tries to state what his daughter should do as a career and what things she likes such as sports; he seems to have a desired outcome and is twisting the truth to get that outcome.

(7) Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others. Tom seemed unable to understand why his wife could not accept him continuing to have affair.

(8) Is often envious of others or believes that others are envious of him. Tom does not specifically meet this symptom.

(9) Shows arrogant, haughty behaviors or attitudes. Tom states how his daughter is "just like him." He seems to point out characteristics of his daughter that he would like; as they are characteristics his daughter denies having. In discussing class lectures, people with Narcissistic Personality Disorder have this tendency to think their children will be successes and representations of them, as clearly Tom indicates.

Disorders considered being assessed for Tom Rogers: R/O Antisocial Personality Disorder due to not getting a full picture of Tom being involved in criminal activity or history of his childhood life; however this is a very high possibility in relation to his deceitfulness with the affair, lack of empathy, and irritability/aggressiveness

• R/O Intermittent Explosive Disorder since no history of severe aggressive impulses (other than abuse incident to Tanya), nor a sense of regret of this physical incident with Tanya.

PDM diagnosis: Tom Rogers P-Axis of the PDM discusses P104.1 Narcissistic Personality Disorder: Arrogant/Entitled subtype. The continuum of severity exists with many personality disorders, including this diagnosis. Tom seems to exhibit a less "arrogant" state than the DSM-IV describes by being less successful and internally preoccupied with grandiose fantasies as noted by his statements of what Trish's likes and possibly due to his perception of what parents and children on basketball team he coaches think about him. However, he does fit the arrogant/entitled due to his "...overt sense of entitlement..." as he believes he should be able to know what his daughter described him as being when she talked to you. He devalues most others such as his wife based on her description of how he seems to exhibit this "I will tell you what to do" mindset, and seems manipulative and commanding: talking on the phone to you he seems very busy, uncooperative, and condescending; yet when he visits you with Trish he seems sly and charming.

Contributing constitutional-maturational patterns: No clear data (as noted by PDM)**.**

Central tension/preoccupation-inflation/deflation of self-esteem: Clearly an inflation of self-esteem as noted by how much he works every day, how he is admired as coach, how he is a great father and good with children, how much Trish is just like him, and how he "knew" what was going on with Trish at school due to her behavior as a result of influence by bad friends. Trish seems to be an extension of his ego with how he highly he regards himself.

Central affects-shame, contempt, envy: Tom seems to reflect a sense of contempt as if there is nothing wrong with the Trish or this court issue. He has this sense of envy in the way he needs people to admire him such as Trish, parents/children of basketball team, and almost for you the therapist to admire him.

Characteristic pathogenic belief about self: I need to be perfect to feel okay. Difficult to say if Tom feels this way, but he seems to be a "workaholic," needs his daughter to be a part of his life and represent him.

Characteristic pathogenic belief about others: Others enjoy riches, beauty, power, and fame; the more I have of those, the better I will feel. Tom seems to feel everyone admires him based on teacher calling him about Trish's behavior and parents and children of basketball team loving him; he most likely believes you will admire him in the same way.

Central ways of defending-Idealization, devaluation: Idealization seems to be how Tom uses his defense mechanism. He has the idea that he is the best and brightest, therefore he devalues everyone else such as Tanya. When Tanya rejected his statement to accept his affair, Tom more than likely, reached to the defense mode of idealization when he became abusive with her to try to get her to see him as "best" and out of anger for not staying with him so he could continue to be admired by her.

Trish Rogers (Daughter)

DSM Diagnosis: Trish Rogers Assessment Multi-axial DSM Diagnosis Is As Follows:

Axis 1 309.24 Adjustment Disorder with Anxiety, Acute
Axis II V71.09
Axis III None
Axis IV Problems with primary support group, educational problems
Axis V GAF=60

Trish Rogers's diagnosis of adjustment disorder with anxiety, acute was given due to diagnostic criteria being met:

A. The development of emotional or behavioral symptom in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s). Trish's is a 9 year old girl whose parents have recently separated about 3 months ago and has communicated how she would like to see her parents back together.

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:

(1) Marked distress that is in excess of what would be expected from exposure to stressor.

(2) Significant impairment in social or occupational (academic) functioning. Trish's academic performance in school has been declining as she states it is hard to pay attention and the other students' misbehavior makes it hard to focus. Trish goes on to state how she is very worried about her mother and very worried about the visit you visiting her father. She shows hyperactivity when she is with her father, which may be a sign of her anxiety-related behavior.

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder. No indication of another diagnostic feature that Trish meets.

D. The symptoms do not represent Bereavement. No indication that Trish has had a loss of a loved on.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than I months. Currently Trish's symptoms are within the 3 months of the acute time period.

Disorders considered being assessed for Trish: R/O separation anxiety disorder due to Trish exhibiting anxiety about mom and her well-being, but is not separated from her primary attachment giver which is her mother. Anxiety about father, but more anxiety when with father, not when separated from him.

- R/O Trichotillomania due to pulling out eyelashes rather than hair; this also did not seem to be a recurrent behavior.

PDM diagnosis: Trish Rogers SCA-Axis of the PDM discusses SCA301 anxiety disorder in children and adolescents: Affect states vary with all children, but there is a usual association of basic safety issues. For Trish, she seems to carry an anxious affect in regards to her worries of her mother (especially after her physical incident), worries when with father, and possibly an overall worry of nervousness due to her performance in school due to peers being unruly and her negative interactions from teacher. She carries a heightened sense of alertness, especially in the presence of father or mentioning of father. This anxiety may be part of the reason for her declining school performance in regards to the subject of math.

Thoughts and fantasies seem to focus on a child's inability to play with usual activities due to the anxiety. This may be the case with Trish but difficult to assess about her daily routines. It may be that she is spending less time with typical child activities and taking on an inappropriate role of a "caretaker" for mother as she seems very anxious about her mother's well-being.

Somatic states include a variety of physiological responses, but no clear physiological indication seems to be occurring to Trish other than pulling out eyelashes such as the time when she was visiting her father and he became angry with a female friend. Hyperactivity she exhibits when near her father may be a sign of her anxiety as well.

Relationships may be interrupted due to anxiety. Social and learning activities may be suffering due to Trish's anxiety, which should be noted as situational due to parents' separation. There seems to be no indication of prior anxiety before the separation. Her relationship with her father is very anxiety provoking and her relationship with the primary caregiver (her mother) is not as mutual as it may have once been due to mother's anxiety and recent stressor of physical incident causing harm to her relationship with daughter and her having to play caretaker role as stated previously.

Psychopathology and trends

The utility of psychopathology in Social Work Practice is commensurate with the social workers' training and supervision. For obvious reasons, an assessment and diagnosis of a client may have life-long consequences; therefore, social workers should have the appropriate education, training, and supervision to warrant such a responsibility. Social work educators need to incorporate case studies, discussions, and practice in their psychopathology courses and other classes such as field education so that students may learn and apply the necessary information. Moreover, it should help the pass rate of the clinical licensing examination. Further, students and recent graduates need to exercise their life-long learning skills by getting as much training as they can for continuing education units (CEUs) to maintain their licenses but, importantly, to become proficient at assessing and diagnosing in practice. This continuous training will also assure that social workers keep abreast of changes and innovations in psychopathology. Professional clinical supervision is necessary not only for licensing but for ongoing feedback for social workers to provide second opinions and guidance, if necessary, and to maintain their clinical skills, particularly in diagnosing. Agency or task supervision is important as a professional safeguard as well.

In a way, psychopathology is a necessary evil in clinical social work practice because social workers cannot bill for their services without the appropriate assessment and diagnosis. Without appropriate education, training, and supervision, social workers may not have the clinical skills to provide or bill their services. The relationships among educating, training, and diagnosing, and billing create problems for those workers who were grandfathered into the profession or licensing and those who work under the supervision of social workers and may not have sufficient education or training. Whereas psychopathology affords a framework for practice, it also requires practitioners to have clinical skills, ongoing education, training, and supervision, critical thinking, and ethical decision-making to assure the protection and proper treatment of clients. Exploring the oft-debated history of psychopathology may assist social workers' understanding of its current trends to improve practice.

In the last three decades, psychopathology has been used to justify assessment, diagnosis, and treatment for clients needing mental health services. Importantly, it has provided the primary rationale for payment from the insurance companies and Medicaid. The somewhat controversial history and contemporary trends, as expressed in the DSM-V, in psychopathology may provide insight

into the progression, integration, and authentication of its use in practice over time. Historically, psychopathology has been defined according to different disciplines, depending on their particular perspectives and treatment modalities. In the eighth century, the classifications warranted debate: how would they be defined? What would the symptoms be? What frequency would indicate impairment? In the 1950s, psychiatrists used multiple personality disorder (now evolved into Dissociate Identity Disorder) to diagnose adults who had been severely abused as children or adults who were difficult or different such as the actress Fannie Farmer. The treatments seem extreme; electroshock therapy or, eventually, lobotomy.

As social workers became more involved in diagnosis and treatment, the use of psychopathology reflected the underpinnings of the profession, to improve client well-being through changes in practice or policy. The purpose for psychopathology, therefore, evolved into specifying information that could explain behaviors so that the workers might better advocate for or improve functioning for their clients. For example, in the 1990s, Attention Deficit Disorder with and without Hyperactivity or as it is now known (a change already), Attention Deficit/Hyperactivity Disorder, Combined type, Predominately inattentive type, or Hyperactive-Impulsive type was a popular way to provide some youth with assistance in the classroom and protect them from being expelled for bad behavior. Today, the glamour diagnosis is pediatric bi-polar, which may be a form of early intervention. Both examples indicate the necessity for early intervention and prevent possible escalation. However, just as beauty is in the eye of the beholder, the diagnosis and its purpose are filtered through the lens of the workers' professions, their clinical practices, treatments, and ethics.

With the impending release of the DSM-V, there is a movement to synthesize and create some agreement and continuity of diagnosing among the different disciplines in psychopathy. There will be more emphasis on being clinician- and patient-friendly, using technology with videos, case studies, and vignettes to help unify the disciplines. Likewise, there is a movement to consolidate the two sets of codes from the DSM-IV and ICD-II so that they will not have so many distinctions. Diagnoses are now focusing on development across the life span, rather than simply children versus adults. In fact, there will be the substantial modifications for specific diagnoses to improve clinical use of the DSM-V, such as pediatric bi-polar and mild neurocognitive disorders. The hope is that in this way, made DSM-V will become more of a living document and psychopathology is becoming homogeneous across the helping disciplines.

Conclusion

Psychopathology has evolved to its present prominence in practice, at least acknowledged as such by some practitioners, over a long, rocky road of personal and professional disputes. It is important for clinicians to understand this evolution in order to remedy past mistakes and offer insight into how history may direct or redirect the way in which a client is assessed, diagnosed, and treated. Ultimately, social workers, as change-agents, are

concerned with doing no harm and improving the well-being of their clients. To understand the historical transformations of psychopathology, social workers must recognize the roles of the different disciplines, each with its own unique perspective, and their contributions to practice. Case interpretations and diagnoses may vary by discipline and by individual practitioner. Therefore, it would benefit social workers to embrace interdisciplinary collaboration to change the way the mental health professionals assess, interpret, and treat clients who among the most vulnerable people. In addition to acknowledging the historical roots of psychopathology, case studies may illustrate examples of issues that can be interpreted differently by discipline. The way in which clinicians interpret cases and provide rationale for treatment may depend on their discipline's theoretical perspectives and view of the clients and their environments. As the trends for the DSM-V indicate, creating a user-friendly, namely clinician-friendly, patient-friendly, and education-friendly, manual will no doubt improve the potential for more accurate, consistent diagnoses. Introducing technology, adding visuals, creating more action, as opposed to reaction, can serve to stimulate better understanding of psychopathology and its primary clinical tool, the DSM. Using psychopathology as a collective underpinning for treatment, perhaps social workers and other disciplines will improve treatment and client safety, health, functioning, and well-being.

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