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ORIGINAL PAPER

"Walking the Tightrope:" Clinical Social Workers' Use of Diagnostic and Environmental Perspectives

Barbara Probst

Abstract The purpose of this study was to understand how clinical social workers think about and utilize two distinct worldviews: the psychiatric perspective of DSM diagnosis (Diagnostic and Statistical Manual of Mental Disorders) and the contextual person-in environment perspective. The former is a requirement for service and reimbursement in nearly every clinical setting, while the latter has always been the hallmark of a distinctively "social work" approach. Although there have been quantitative surveys of social workers' use of the DSM, this is the first qualitative study to examine how social workers actually navigate these two worldviews. Thirty clinical social workers took part in individual interviews, and their responses were analyzed thematically using HyperRESEARCH, a qualitative data management program. Findings reveal an array of ethical and practical issues, including the central "tightrope" of balancing the need to "ramp up" problem formulation in order to access service with the desire to "damp down" in order to minimize stigma and avoid pathologizing problems in living. Implications are addressed for social work practice, policy, and education.

Keywords DSM · Diagnosis · Person-in-environment · Clinical decisions · Ethical dilemmas

Introduction

Social workers now provide more therapeutic services than any other group of professionals (Kirk 2005). There are more clinically trained social workers than psychiatrists, psychologists, and psychiatric nurses combined: 60 % of mental health professionals are clinically trained social workers, while 10 % are psychiatrists and 23 % are psychologists (http://www.socialworkers.org/pressroom/features/general/profession.asp); in addition, nearly every field of social work practice has a mental health component. Although social workers are one of the fastest-growing professions in the nation (http://www.bls.gov/oco/ocos060.htm) and thus are likely to continue their role as primary mental health treatment providers, little is known about how they go about their work in an era when *non*-social work assessment (psychiatric diagnosis) is the gatekeeper to service, the hub around which treatment planning and evaluation take place.

How, in fact, *do* social workers engage in work shaped and legitimized by the medical profession, while still taking the broad contextual view that has always been the hallmark of a distinctly "social work" approach? The aim of this study was to understand how clinical social workers think about and work with two distinct worldviews: the diagnostic perspective of the Diagnostic and Statistical Manual of Mental Disorders or DSM (emphasizing an internal locus for individual "disorder") and the person-in-environment perspective (emphasizing the interaction between individual and context).

The study addresses a surprising gap in the research literature. There have been quantitative surveys about social workers' use of the DSM (e.g., Kutchins and Kirk 1988; Frazer et al. 2009), content analyses of social workers use of the environmental perspective (e.g., Rogge and Cox 2001; Weiss-Gal 2008), and experimental studies

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of how social workers make clinical decisions. (e.g., Buchbinder et al. 2004; Kirk and Hsieh 2004; Wainwright et al. 2010). Other literature has focused on the role of the DSM in social work curricula (e.g., Raffoul and Holmes 1986; Newman et al. 2007) or the impact of DSM language on clinical practice (e.g., McQuaide 1999; Ishibashi 2005). Still other literature has consisted of suggestions for alternative perspectives on clinical assessment (e.g., Dewees 2002; Epple 2007; Satterly 2007). Yet there has been a startling lack of research to explore social workers' own views and experiences navigating these two paradigms.

Quantitative researchers agree that in-depth qualitative research is needed to explore questions such as: "Does the requirement for a DSM diagnosis de-emphasize the attention we pay to contextual issues (including culture, relationships, oppression, social justice, economics)?" and "What price are we as a profession paying for buying into the DSM system and its firm allegiance with the insurance industry?" (Frazer et al. 2009, p. 336). To these questions might be added: What can experienced clinical social workers tell us about giving and using psychiatric diagnosis in the "real life" settings of a culturally, socially, and economically complex world? What is it like for them and for their clients? How can their experience inform social work education, policy, and practice?

With the increasing dominance of managed care as the gatekeeper to service and reimbursement (Reamer 1997; Wolfson 1999) as well as the forthcoming publication of DSM-V, which is likely to focus renewed attention on the nature and role of diagnosis, this study is especially timely. The "debates" of past decades (e.g., Kutchins and Kirk 1995 "versus" Williams and Spitzer 1995) are no longer useful. Instead of being concerned about *whether* clinical social workers use or should the DSM—since in today's climate they must—it is crucial to understand how, when, and why they use it (McQuaide 1999).

Methods

This was an exploratory, inductive study within a realist epistemological framework (House 1991). Cognitive heuristics—e.g., the work of Croskerry (2003) on the role of priming, anchoring, and availability on diagnostic choices and Berlin and Marsh (1993) on how social workers make clinical decisions—served as a sensitizing theoretical framework. A qualitative approach to data collection, analysis and interpretation was selected as a means to access participants' subjective meanings in rich detail. Within the qualitative paradigm, thematic analysis (Boyatzis 1998; Braun and Clarke 2006) was chosen for its flexible yet grounded approach. Thematic analysis is an inductive method for identifying, analyzing, and reporting patterns within the data. It allows the researcher to use a bounded, theoretical question as a starting point for identifying themes that can shed light on a pre-determined area of interest. Themes, patterns, and relationships emerge directly from the data, without use of a priori constructs yet within a specified research topic. Theoretical conclusions are drawn if appropriate but are not required.

The study was approved by the Institutional Review Board at Fordham University, New York, and was carried out in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki. Confidentiality of all participants was maintained throughout.

Research Aims

The purpose of this study was to explore the following open-ended questions:

1. How do clinical social workers view, experience, and utilize the medical/diagnostic (DSM) perspective in their work? This question included exploration of the meaning of various psychiatric diagnoses to both client and clinician, how diagnostic decisions were made, if and how diagnoses were shared with clients, and any changes in the clinician's attitude or use of the DSM over time.
2. How do clinical social workers view, experience, and utilize the ecological/person-in-environment perspective in their work? This question included how participants understood the term "environment," the role of environment in both assessment and intervention, and whether perception and use of environment had changed during their professional careers.
3. What do they feel are the merits and limitations of each perspective? What does each contribute to the clinical work, and what does each leave out? Are there disadvantages to using either perspective and, if so, how and when do these disadvantages appear, and how are they addressed?
4. How do they put the two perspectives together? Do they experience any conflict between the perspectives? If so, how do they address this conflict? If not, how does the interplay between the two perspectives take place in "real" practice? Under what conditions might one dominate or appear more salient? What other factors mediate between the two worldviews?

Because much of the literature about social work and the DSM has been couched in polarized (and polarizing) terms, the study sought to move beyond a *yes/no* debate and to explore whether there might be more nuanced, integrative, and complex ways that social workers utilize DSM diagnosis within a person-in-environment framework.

A two-fold approach was thus incorporated into the interview protocol. Questions addressed the existing conceptualization of the two worldviews as separate perspectives, seeking information about participants' views and use of each independently of the other. At the same time, questions were also posed to elicit non-polarized data, alternative conceptualizations, and "surprises"—new data serving as disconfirming evidence in light of the historical and linguistic tendency toward dichotomization. An iterative approach was sustained throughout the study, with data collection and data analysis taking place in a simultaneous, mutually interactive fashion as a check against simplistic or premature categorizations.

Participants

The sampling frame for the study consisted of members of local chapters of two professional social work organizations, the National Association of Social Workers and the New York State Society for Clinical Social Work. Presentations were given at chapter meetings, and informational flyers were distributed at the meetings as well as via follow-up email to the chapters' electronic listservs. Those who were interested in participating were invited to contact the researcher.

All those who expressed interest were given detailed information about the study, including a copy of the Informed Consent form; all participants gave their informed consent prior to inclusion in the study. Four volunteers were excluded because they did not meet criteria of having a professional social work license and/or experience in "traditional" social work settings such as an agency, clinic, school, or hospital. It was also decided to exclude those whose experience was limited to therapy in private practice as a guard against potential bias toward the diagnostic perspective. Two other individuals who expressed interest and met study criteria were contacted but failed to respond to attempts to set up interviews, resulting in an initial sample of 25 clinical social workers practicing in Westchester County and New York City.

During one of the early interviews, the role of *race* and *racism* emerged as potentially significant. Given the low percentage of racial diversity in the original sample, it was determined that more voices were needed in order to thicken this category. (Note: even though race was not one of the study questions, an inductive and iterative approach requires the researcher to follow emergent themes.) Additional participants of color were therefore recruited through iterative theoretical sampling in order to elicit richer data about the role of race in diagnosis; a return to the literature (e.g. Neighbors et al. 1989) lent support to this decision. The final purposive sample of 30 participants thus included seven minority clinicians, or 23 % of the sample. This was greater than the percentage in both Frazer et al's 2009 study, which included 8.3 % minority participants, and NASW's national survey (Center for Health Workforce Studies and National Association of Social Workers 2006) which included 15 %.

Gender, on the other hand, did not appear to be a significant factor. While only four participants were male (13 % of the sample, contrasted with 27 % in Frazer et al's study and 19 % in the NASW survey), responses to research questions did not differ by gender so additional iterative sampling along this dimension was not indicated. Other demographics resembled those of the earlier studies. As in the 2009 study, participants averaged 22 years of experience; data on age was not collected per se, though date of MSW degree and years of experience (ranging from 2 to 47) served as a rough proxy (Table 1).

During the design stage of this research, *years in practice* was considered as a factor of potential importance, both because of the era during which a person was trained—each era having its characteristic theories and emphasis—and because experience may shape, mellow, exacerbate, or crystallize views about diagnosis. Fortunately, variation along this dimension was well represented among those who volunteered for participation, even though it was not explicitly sought during recruitment.

Practice setting was also considered as a potentially significant factor because of the impact of funding source and power structure on the use of DSM diagnoses; here too, a wide range of past and current settings/populations was present in the sample and further sampling along this dimension was not necessary. Participants' work experience spanned a wide range of settings: 13 participants worked for comprehensive social service agencies, 10 in hospitals, 4 in community mental health clinics, and 6 in schools or residential treatment centers. Potential limitations of the sample included its voluntary nature, which may have skewed participants toward those with more extreme or intense views, as

Table 1 Demographic comparison with national population of social workers

	Average age	Average years of experience
NASW study	49	N/A
This research	N/A	22 (range 1-47)
	% Males	% Females
NASW study	19	81
This research	13	87
	% White	% Non-white
NASW study	85	15
This research	80	20

Table 2 Professional experience of participants

	Number	% of sample
Previous experience		
Social service agencies	14	47
Psychiatric hospitals	11	37
Community clinics or programs	4	13
Public schools	3	10
Adolescent residential treatment centers	3	10
Prisons or with paroled individuals	2	7
Affiliation at time of interview		
Private practice only	17	57
Supplemental private practice part-time	3	10
Clinic or agency only	6	20
Other (school, prison, etc.) only	4	13

well as the regional nature of the pool that might not reflect the practice experience of social workers in other parts of the country (Table 2).

Data Collection

Each participant took part in an individual 1-h, face-to-face interview at a time and location of his/her choice. Interviews took place during October and November 2010, and were audiotaped with participants' permission. In order to guard against an implication that either perspective was more important than the other, an alternating protocol was used, with half the interviews beginning with questions about use of the DSM and the other half beginning with questions about use of the person-in-environment approach. At the conclusion of the interview, participants were invited to add any other comments they wished to make about topics or concerns that might not have arisen during the conversation.

Follow-up interviews were conducted by telephone 2 months later, in January 2011, with one-third of the participants, selected to capture demographic representation. These second interviews served as a member check to review preliminary findings for authenticity and trustworthiness, and also as a means for collecting additional data about emergent themes, disconfirming evidence, and alternative viewpoints. No one who was invited to take part in a second interview declined to do so.

Data Analysis

Interviews were recorded, transcribed, coded using hyperRESEARCH, a qualitative data analysis program, and analyzed thematically. A three-step coding procedure was employed: in vivo codes were identified within individual interviews; codes were collapsed across interviews, sorted, and renamed into groups; and then codes were clustered into themes. Both codes and themes were re-checked by a repeated return to the raw data, in both its original (audio) and transcribed forms, paying special attention to what might have been left uncoded, prematurely coded, or miscoded.

Authenticity and trustworthiness were addressed in several ways. In addition to the member check described above, a peer review was conducted with a second group of clinicians, similar to the sample in demographics and background, who were invited to provide feedback on preliminary findings. Potential researcher bias was addressed through memo-writing and mindful journaling, potential respondent bias through withholding of information about the researcher's previous work on the use of psychiatric labels. Audit trail and an iterative return to both the literature and the raw data also served to enhance trustworthiness.

Findings

Views and Utilization of the Medical/Diagnostic Perspective of the DSM

Participants found the DSM useful (though not central), despite its limitations and despite the significant ethical concerns and dilemmas it evoked. Most considered DSM diagnosis more useful for helping clients make sense of their experience than as a guide for choice of intervention, although this was moderated by severity of the disorder and was more salient for certain diagnoses and in certain practice settings. In addition to its role in facilitating reimbursement by third-party payers, respondents found the DSM useful for medication decisions, communication, and continuity of care. Common themes were that DSM diagnosis served as a "starting point" and was helpful for psycho-education, validation of a person's suffering, and formulation of realistic hope.

The advantages of psychiatric diagnosis listed by McQuaide (1999) were all noted: a sense of control (for both client and clinician), reduction of anxiety or blame, indications for appropriate questions and interventions, legitimization of experience, and opening a path to recovery. Participants felt strongly, however, that diagnosis must be used with caution because of its incompleteness, inaccuracy, "stickiness," "blurriness," (i.e., overlapping criteria), tendency to foster premature closure, and the haste with which it is typically made due to agency and insurance requirements. They did not mention some of the other limitations noted in the literature, however, such as a lack of concern for the etiology of a disorder (Wakefield 2005) or the cultural construction of mental illness (Sands 2001; Mechanic 2008). The impact of racism, ethnocentricity, and folkloric notions of illness/wellness was brought up *only* by clinicians of color; white clinicians, when asked, did agree that culture was important but none spoke about racial bias in diagnosis unless prompted. Selecting a diagnosis and sharing the diagnosis with the client were complicated topics that raised ethical concerns including confidentiality, stigma, making someone in a family the "sick one," and having to assign a more "serious" DSM label in order to obtain services. A number of participants remarked the interview experience made them realize that they used diagnosis more, and in more ways, than they had realized.

The role of DSM diagnosis appeared to vary with experience, practice setting, and type or severity of the disorder. Some disorders played a greater role in shaping therapy than others, although ultimately participants did not feel that a client's diagnosis was what guided their work. In contrast with the evidence-based practice model (McNeil 2006), none of those interviewed mentioned that knowing a person's diagnosis directed them to search for empirically-supported treatments linked to that disorder. Although some authors caution that "privileging the DSM's categories can lead to the assumption that if a client's problems do not fit into one of the categories, then the client doesn't have a valid emotional illness" (McQuaide 1999, p. 411), respondents did not appear to fall prey to this assumption. Instead of concluding that the client had no "real" illness, they "played the game" and "did the dance" to select a DSM category that fit well enough to merit services and reimbursement. In accordance with the literature on clinical decision-making (e.g., Reamer 1997; Wolfson 1999), they were willing to "stretch the severity" of a client's condition if necessary, but not beyond the point where they felt ethically compromised.

Views and Utilization of the Person-in-Environment Perspective

Opinions about the role of environment were more consistent across interviews than opinions about the DSM, with commentary was less richly nuanced—almost as if the importance of the environment was so obvious as to not require explanation or elaboration. Environment provided a "panorama," enhanced empathy and understanding, and offered supplemental avenues for intervention. While participants felt it was essential to view clients in their entire life contexts, they did not find environment as a concept to have as much weight or "clinical power" as diagnosis for understanding or indicating how they might be able to help.

Those interviewed tended to include far more in the notion of "environment" than physical and socio-cultural context. They spoke about relationships, social capital, poverty, culture, life stressors, family history (how the person was raised, events in the family narrative such as loss or transition, family dynamics), and personal history (salient events, presence or absence of models, past traumas or crises, attachment ruptures, experiences of coping, cumulative adversity or privilege). In broadest terms, they conceived of environment as something existing over time and shaped by time, the cumulative effect of "what people have had to bear" and how they have survived.

Perhaps because of the way the research questions were posed, many respondents seemed to take "environment" to mean everything *but* biology and psychiatric diagnosis. Since they were invited to speak about environment however they wished, their responses were wide-ranging and, in aggregate, resulted in a "laundry list" of factors that *might* matter, rather than a clear conceptualization of *how* they mattered. This echoed Rogge and Cox's conclusion (2001) that environment tends to be conceived by social workers in broad, flexible, non-specific ways and that "either the perspective is so ingrained in social work practice that there is no need to name it, or that it is much less a guiding perspective than the profession may claim or believe" (p. 64). Some authors such as Wakefield (1996) maintain that environment, as a concept, is simply too vague and general to be useful for explanation, prediction, or intervention planning. This study appears to support Wakefield's views: while participants agreed that clients needed to be seen in their full life context (a "full 360 degree picture"), this was for the sake of greater empathy and understanding, not as a guide to treatment.

Participants did, however, feel strongly that environmentally driven distress and dysfunction should be seen as legitimate treatment needs without having to be couched in the language of mental disorder. Many felt pressured and compromised by having to find a psychiatric term to justify helping someone with relationship issues or problems in living, although they struggled with distinguishing problems exacerbated by the environment (yet possibly neurobiological in origin) with problems created primarily by environmental stressors. While some authors such as Wakefield (2005) emphasize the importance of distinguishing "true" mental disorders from problems caused by a "normal" response to a difficult environment, "whether or not they are incorrectly labeled as disordered for reimbursement purposes" (Wakefield 2005, p. 87), participants in this study saw the two kinds of distress as complexly interwoven. Sometimes, but not always, they were able to distinguish situational from internal disorder by history and chronicity; nonetheless, they felt environment played a key role in *all* disorders, even those of organic origin.

Relationship Between the Two Perspectives

Respondents did not report experiencing a conflict between the two perspectives, but made use of both in a reciprocal, mutually interacting, and holistic manner as *both/and* rather than *either/or*. They saw the two worldviews in dynamic inter-relationship and felt it was important not to minimize or marginalize *either* perspective: to withhold or downplay a psychiatric diagnosis when it was truly indicated would do a client as much disservice as attributing a problem stemming from contextual or relationship issues to internal dysfunction. In their experience, both lenses were necessary, though neither was sufficient; separating the two perspectives seemed to them misleading and intellectualized.

> I don't have one orientation. I don't only look at one thing. Now, if I only looked at the person in the environment, then that would be limited. And you'd miss some other things. But I wouldn't do that. The only way that makes sense to me is to see what's going on with the patient, first and foremost. What are the factors that are influencing the situation, and then attending to them without some sort of a template that I'm interpreting everything within.

> You can't say there's two different roads. They're not two different roads. It's the same road, and you're in the car and you're looking at different things, but it's not a different road. And if you do that, then I don't think you're doing treatment. You can't be doing treatment because you can't separate them. I don't think anyone who's actually practicing in the field can. I think it's an intellectual exercise to think that you do or you can.

Still, when asked if they would give a psychiatric diagnosis if not required to do so, a majority of participants replied that they would not. They might still think symptomatically or describe someone as "experiencing depression," but would not necessarily assign the person to a psychiatric category.

> I wouldn't necessarily come up with a diagnosis. I would come up with a picture of the patient and what they're struggling with, what their issues were. I wouldn't necessarily think diagnoses, where it will fit in the DSM.
> I would rather just hear what is the problem, help the person figure out what to do, without having to worry about what their diagnosis is. I only use it if I have to.

Overall, participants were generally satisfied with how they were able to meet the needs of their clients and the needs of their profession.

> I'm very fortunate at this point to be able to sort of boil all of the things together in this wonderful, big cauldron, making a nice nourishing soup for myself out of all of the different experiences I've had in my life.

> I feel like I have elected to participate in a profession that believes in the journey, as opposed to having to put a fix on this, a quick fix, whether it's medication or diagnosis or whatever. And I feel like there's a certain luxury in being able to be with a person as part of this journey, and then to participate with them in it.

> I think that we've done a pretty good job of satisfying the DSM and the managed care companies, plus bringing in our own viewpoint. We give them their diagnosis, we delineate the symptoms, but we also deal with the systems they're circulating in, the environment they're in. And I think we've been pretty successful in helping them, while satisfying the DSM.

Discussion

Participants in this research were comfortable with a fluid, eclectic approach and use of a diverse clinical palette. They saw diagnostic and ecological perspectives as a two-sided coin, the environment potentiating or inhibiting a person's constitutional, psychological proclivities. In a stressful environment, for instance, a tendency toward depression might be more easily activated; with fewer resources to mitigate the depression, additional stressors, and more barriers to obtaining help, the disorder might escalate and lead to greater overall impairment and a more serious trajectory. In a more privileged environment, on the other hand, the same depressive tendencies might manifest in a milder form or even be kept at bay.

Many noted that patterns over time helped to differentiate biological/psychiatric issues from environmental ones. Since a behavioral symptom could be indicative of an entrenched disorder or a more transient experience of adversity or frustration, they did not find observable symptoms sufficient for distinguishing neurobiological conditions from situational ones (Kirk and Hsieh 2004; Wakefield 2005)—despite the DSM taxonomy's reliance on only what can be observed, and despite their use of that taxonomy when required to do so. In practice, however, they stressed that a thorough assessment was necessary to explore patterns, previous episodes, family and personal history, and response to treatment, as well as presenting symptoms.

Most, however, considered a third factor, the therapeutic relationship, to be more essential to their practice than either perspective, alone or in combination (Beutler and Harwood 2002). Neither perspective captured what was most important in their work: listening, attunement, personal narrative, story, "being where the client is," "just sitting with the person in front of me," and "being with the person in the moment." Most participants also reported utilizing additional lenses, not just the ecological framework and the DSM—psychodynamic theory, family system models, cognitive methods, and newer theories such as internal family systems and emotion-focused therapy. Still, it was not the theoretical model but the therapeutic relationship itself that really mattered.

Setting, managed care, and client variables (such as strength, motivation, and characteristic style of functioning) also played a role. These three clusters, separately and together, influenced how participants made use of diagnostic and ecological lenses. Although *years in practice* was postulated as a significant factor for understanding the relative use of ecological and diagnostic perspectives, there were no clear differences in the interviews based on years of experience. Instead, *practice setting* emerged as significant; not *how long* but *where* one worked affected one's experience and thus one's viewpoint, through moderating elements such as funding source, time constraints, source of authority, and issues of status and power. In hospital settings, for instance, psychiatrics were "in charge" and had the final say, while in some agencies authority resided with senior social workers. In other settings, such as schools and prisons where treatment funds came through government rather than insurance, psychiatric diagnosis was less central.

Although those who had worked only as therapists in private practice were excluded from the study, the question of private practice versus agency or clinic proved to be a "red herring." The need for DSM diagnosis was the same regardless of whether the billing was done by the clinic or by the individual clinician, as were the concerns about how to frame couple or family work and how to select a diagnosis serious enough to satisfy managed care yet benign enough not to be stigmatizing. In fact, nearly all the participants, even if they worked for an agency, had a small private practice "on the side." This became a natural laboratory for asking them to compare their experience in the two settings. As it turned out, however, there were more differences *among* non-private practice settings than *between* private practice and clinic practice.

The role of managed care proved more central than anticipated (Reamer 1997; Mechanic 2008). It was the insurance companies and their insistence on a DSM diagnosis, not the DSM itself as a taxonomic system, that constrained and even angered participants. Had they felt free to choose if, when, and how to use psychiatric diagnoses, they would have felt less resentful than they did under managed care's *requirement* to do so. Many were bitter about insurance companies "telling us how to conduct our professional practice."

In general, participants found managed care to be problematic, constraining, and disempowering for both clinician and client. To be billable under Axis I, family, couple or relationship issues required someone to be the "sick one," creating a trail of labels that might have unforeseen stigmatizing consequences. Similarly, problems in living such as job loss had to be framed as depression, anxiety, or adjustment disorder. Creativity and collusion were necessary in order to obtain needed service; sometimes family members alternated "sick roles" in order to make sequential use of each person's insurance, and sometimes progress had to be minimized in order to merit authorization for additional sessions.

Ethics and *ethical choices* emerged as over-arching concepts (Reamer 1997; Wolfson 1999). Managing the "dance" or "tightrope," coping with "grey zones," selecting a workable diagnosis, sharing that diagnosis with the client, making one's peace with "the system"—these ethical dilemmas made the interplay between the diagnostic and environmental perspectives a highly personal, fluid, and sometimes uncomfortable process. Values and pragmatics had to be weighed anew with each client (Berlin and Marsh 1993). Rather than cognitive heuristics such as anchoring and availability (Croskerry 2003), participants used *value heuristics*, reaching for phrases such as "I do what I have to do" and "It's just something I put down for insurance." They accepted the necessity to "play the game," to split paperwork and practice, as long as they felt they were providing the best care they could. Overall, clinicians who took part in this study were most concerned with the ethical question of balancing severity ("ramping up" in order to legitimize access to service) with potential stigma ("damping down" in order not to pathologize problems in living). They selected the most benign, the "least diagnosis" that would still ensure coverage, some distancing themselves from the process and others stating flatly, "It's fraud." To refuse to "play the game" was unrealistic; it would limit treatment to those who could side-step insurance and self-pay, an option that participants felt would be worse because it would result in greater inequity.

Implications and Conclusions

These findings point to a number of important implications for social work practice, education, and policy. Workshops and mentoring in models of clinical decision-making can be provided to help new social workers utilize the DSM in ways that are meaningful, practical, and ethical. In addition, broader models of intake/assessment, treatment planning, and evaluation may be needed that are not inexorably linked to DSM diagnosis, including greater latitude for delayed diagnosis.

To better prepare the next generation of clinicians, integrative teaching modules may need to be developed that reflect real world practice, rather than (as is typically done in MSW curricula) teaching DSM assessment and models of practice as separate courses. It may also be helpful to re-visit how "environment" is conceptualized and integrated into the practice curriculum, especially in light of the limited literature on social workers' understandings of the term.

It may also be time for social workers to claim a stronger voice in the application and evaluation of DSM-V, given their role as primary mental health treatment providers, as well as the economic disparity in treatment options and cultural bias in diagnosis and treatment to which social work, as a profession, has an acute sensitivity. This may help to bridge the century-old divide within the profession between macro and micro practice, while paving the way for equitable access to treatment and fruitful practice-based research in the service of social justice and the betterment of all.

Conflict of interest The author declares that there is no conflict of interest.

References

Berlin, S. B., & Marsh, J. C. (1993). *Informing practice decisions*. New York: MacMillan.

Beutler, E., & Harwood, T. M. (2002). What is and can be attributed to the therapeutic relationship? *Journal of Contemporary Psychotherapy, 32*(1), 25–33.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks CA: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101.

Buchbinder, E., Eisikovits, Z., & Karnieli-Miller, O. (2004). Social workers' perceptions of the balance between the psychological and the social. *Social Service Review, 78*(4), 531–552.

Center for Health Workforce Studies & National Association of Social Workers, Center for Workforce Studies. (2006). Licensed Social Workers in the United States, 2004.

Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them. *Academic Medicine, 78*(8), 775–781.

Dewees, M. (2002). Contested landscape: The role of critical dialogue for social workers in mental health practice. *Journal of Progressive Human Services, 13*(1), 73–91.

Epple, D. M. (2007). Inter and intra professional social work differences: Social work's challenge. *Clinical Social Work Journal, 35*, 267–276.

Frazer, P., Westhuis, D., Daley, J. G., & Phillips, I. (2009). How clinical social workers are using the DSM-IV: A national study. *Social Work in Mental Health, 7*(4), 325–339.

House, E. R. (1991). Realism in research. *Educational Researcher, 20*(6), 2–9.

Ishibashi, N. (2005). Barrier or bridge? The language of diagnosis in clinical social work. *Smith College Studies in Social Work, 75*(1), 65–80.

Kirk, S. A. (2005). Critical perspectives. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives*. Columbia: Columbia University Press.

Kirk, S. A., & Hsieh, D. K. (2004). Diagnostic consistency in assessing conduct disorder: An experiment on the effect of social context. *American Journal of Orthopsychiatry, 74*(1), 43–55.

Kutchins, H., & Kirk, S. A. (1988). The business of diagnosis: DSM-III and clinical social work. *Social Work, 33*, 215–220.

Kutchins, H., & Kirk, S. A. (1995). Should DSM Be the Basis for Teaching Social Work Practice in Mental Health? No! *Journal of Social Work Education, 31*(2), 159–165.

McNeil, T. (2006). Evidence-based practice in an age of relativism: Toward a model for practice. *Social Work, 51*(2), 147–156.

McQuaide, S. (1999). A social worker's use of the diagnostic and statistical manual. *Families in Society, 80*(4), 410–417.

Mechanic, D. (2008). *Mental health and social policy: Beyond managed care* (5th ed.). Boston: Allyn & Bacon.

Neighbors, H. W., Jackson, J. S., Campbell, L., & Williams, D. (1989). The influence of racial factors on psychiatric diagnosis: A review and suggestions for research. *Community Mental Health Journal, 25*(4), 301–311.

Newman, B. S., Clemmons, V., & Dannenfelser, P. L. (2007). The diagnostic and statistical manual of mental disorders in graduate social work education: Then and now. *Journal of Social Work Education, 43*(2), 297–307.

Raffoul, P. R., & Holmes, K. A. (1986). DSM-III content in social work curricula: Results of a national survey. *Journal of Social Work Education, 22*(1), 24–31.

Reamer, F. G. (1997). Managing ethics under managed care. *Families in Society, 78*(1), 96–101.

Rogge, M. E., & Cox, M. E. (2001). The person-in-environment perspective in social work journals: A computer-assisted content analysis. *Journal of Social Service Research, 28*(2), 47–68.

Sands, R. G. (2001). *Clinical social work practice in behavioral mental health: A postmodern approach to practice with adults* (2nd ed.). Boston: Allyn & Bacon.

Satterly, B. A. (2007). The alternative lenses of assessment: Educating social workers about psychopathology. *Journal of Teaching in Social Work, 27*(3/4), 241–257.

Wainwright, S. F., Shepard, K. F., Harman, L. B., & Stephens, J. (2010). Novice and experienced physical therapist clinicians: A comparison of how reflection is used to inform the clinical decision-making process. *Physical Therapy, 90*(1), 75–88.

Wakefield, J. C. (1996). Does social work need the eco-systems perspective? *Social Service Review, 70*, 1–30.

Wakefield, J. C. (2005). Disorders versus problems of living in DSM: Rethinking social work's relationship to psychiatry. In S. A. Kirk (Ed.), *Mental disorders in the social environment: Critical perspectives*. Columbia: Columbia University Press.

Weiss-Gal, I. (2008). The person-in-environment approach: Professional ideology and practice of social workers in Israel. *Social Work, 53*(1), 65–75.

Williams, J. B. W., & Spitzer, R. L. (1995). Should DSM Be the Basis for Teaching Social Work Practice in Mental Health? Yes! *Journal of Social Work Education, 31*(2), 148–153.

Wolfson, E. R. (1999). The fee in social work: Ethical dilemmas for practitioners. *Social Work, 44*(3), 269–273.

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