Box 10.2 (*continued*)

reactions to these experiences, rather than signs of mental illness.

There is concern that the broad diagnostic criteria in the *DSM* are often used to enforce conformity to mainstream social norms rather than to diagnose mental illness. Behaviors that might threaten dominant cultural values are stigmatized and labeled as mental illness. Individuals and groups of people can be forced into treatment or punished by being removed from society if they stray too far out of line. For example, some slaves were diagnosed as having *drapetomania*, a term coined by a southern doctor in the 1850s as a pejorative label for an "uncontrollable urge to escape from slavery" (Hare-Mustin & Marecek, 1997, p. 106). Today the diagnostic category conduct disorder can be applied to adolescents who are acting out, even if their behavior is a reasonable response to problematic situations in their lives.

There is often disagreement about whether a behavior should be included in the *DSM*. Some say that inclusion is at times based on "political compromise rather than scientific consensus" (Kutchins & Kirk, 1997, p. 99). One often-cited example is the 1974 struggle over whether to remove homosexuality from the *DSM*. Many feel that the decisions to include and to later remove it were made on political and moral rather than scientific grounds.

Finally, some people worry that the overuse of diagnostic labels will infringe on patients' rights. Insurance companies generally require a diagnosis from the *DSM* before they will reimburse for services. This puts practitioners in the position of having to give a diagnosis that may not be accurate so that a client can receive services. Research suggests that people with a mental illness diagnosis are perceived as less likely to recover than people with a physical illness (Ben-Zeev, Young, & Corrigan, 2010). The means that the label they are given when diagnosed may stay with them for their entire life, putting them at risk of employment or other types of discrimination. Many managed care companies use the symptoms listed in the *DSM* as a guideline for appropriate treatment. This can mean ignoring the environmental and social context of a patient's distress. The *DSM* itself "implies that psychological disorders are closely akin to physical disorders, and that they exist apart from the life situations and cultural backgrounds of those who experience them" (Hare-Mustin & Marecek, 1997, p. 107).

Kutchins and Kirk sum up concerns about increasing reliance on the *DSM*:

> There are certainly many people who are troubled and plenty of individuals and families made miserable by mental illness. DSM is intended to describe these illnesses and identify those who have them. But DSM oversteps its bounds by defining how we should think about ourselves; how we should respond to stress; how much anxiety or sadness we should feel; and when and how we should sleep, eat, and express ourselves sexually. Although people inevitably base these judgments on personal and social values, the APA tries through the DSM to extend its professional jurisdiction over daily life by arguing that its descriptions of illnesses are based on science. (1997, p. 15)

Box 10.3 What Do You Think?

Should professional organizations define mental disorders? If not, who should?

Social Work Practice in Mental Health Settings

Social workers with expertise in mental health practice in a variety of settings, including public community mental health centers, nonprofit and for-profit provider agencies that contract to treat public mental health clients, state and county hospitals, private psychiatric hospitals, psychiatric units in general hospitals, Department of Veterans Affairs psychiatric services, and private practice

Table 10.2 More about Major Psychiatric Diagnoses and Their Treatment

DSM-IV Diagnosis	Etiology	Prevalence	Evidence-Based Psychosocial Interventions	Evidence-Based Pharmacological Interventions
Anxiety Disorders Panic Disorder, Generalized Anxiety Disorder, Social Phobia, Obsessive-Compulsive Disorder	The development of an anxiety disorder comes from a combination of life experiences, psychological traits, and/or genetic factors. Panic disorder appears to have the strongest genetic base.[1]	It is estimated that 16% of the population has some type of anxiety disorder.	Cognitive behavioral therapy[2] Exposure and response prevention for OCD[3]	Benzodiazepines: e.g., alprazolam (Xanax), clonazepam (Klonopin) Antidepressants: e.g., fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox)
Mood Disorders Depression, Bipolar Disorder, Dysthymia	Depressive episodes may be triggered by stressful life events. It is believed that there is a biological component. However, it is not clear if biological abnormalities cause depression. Perhaps they only correlate with depression. Research has demonstrated that chronic stress affects brain function, and depression may be the result of severe and prolonged stress[4]. Social, psychological, and genetic factors may act together to protect against or predispose to depression. Depression and bipolar disorder do run in families, especially in the case of bipolar disorder.	It is estimated that 7% of the population has some type of mood disorder.	Cognitive-behavioral therapy[4] Interpersonal therapy[5]	Antidepressants: e.g. fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil) Bipolar: lithium carbonate, divalproex sodium (Depakote)
Borderline Personality Disorder	As yet unknown, but some evidence of genetic factors, familial factors or history of childhood sexual abuse.[7]	Affects about 2% of the population	Dialectical behavior therapy[6]	Serotogenic antidepressants, e.g., fluoxetine Low doses of haloperidol, thioridazine, risperidone

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