

CHAPTER III

ASSESSMENT, DIAGNOSIS (including psychopharmacology) AND INTERVENTION PLANNING

ASSESSMENT

Assessment is a critical element in the treatment of a client. Assessment refers to the process of arriving at tentative conclusions about the nature of the client's situation, including problems and resources. It provides the basis for treatment planning. Assessment should be an ongoing process. Mary Richmond was one of the first practitioners in casework to concentrate on assessment and diagnosis. Assessment should focus on many different aspects of the client's internal and external experience, including the following:

Intrapersonal Systems

- Biophysical functioning
- Use and abuse of alcohol and drugs
- Cognitive/perceptual functioning
- Emotional functioning
- Mood disorders (formerly called Affective disorders)
- Behavior functioning
- Motivation
- Precipitating events and motivation
- Degree of acculturation
- Language fluency
- Problem solving skills

Environmental Systems

- Health and safety factors
- Social systems
- Social support systems
- Environmental needs of adults and children
- Cultural norms
- Precipitating events

An accurate assessment is based on a careful gathering of relevant data about the client. Some of the leading methods for data gathering in clinical settings include clinical interviewing, tests and other assessment tools (e.g., MMPI, Thematic Apperception Test, genogram, ecomap, social assessment history, mental status exam), observation of the client, client self-monitoring, collateral information (e.g., parents and teachers) and existing documents (e.g., school and medical records). Data that is obtained using a variety of methods results in a more accurate assessment.

Abuse and Neglect varies in severity, from abuse which results in superficial injury (e.g., bruises) to abuse which results in death. The most common perpetrator of physical abuse of

a child under the age of 14 is the female parent. Although the definition of child abuse varies from state to state, social workers and other mental health workers, teachers, health care professionals, and doctors are **required by law in all states to report child abuse**.

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Elder Abuse is typically inflicted by family members and occurs in a variety of forms including verbal, emotional, and physical abuse, neglect (the most commonly reported form of abuse), and wrongful taking of their assets. Sexual abuse of the elderly seems to be relatively rare. Severe abuse may be experienced by as many as three percent of the elderly each year in the United States alone. This form of abuse often goes undetected either because victims are unable to make reports or because they fear that their abusers will retaliate with an escalation of the abuse or by having them institutionalized. Factors that may contribute to the abuse of the elderly include poverty, substance addictions, and difficulty holding down a job. However, even in the absence of these conditions, middle-aged caretakers may become abusive in response to the challenge of juggling work, care of dependent children, and care of an elderly parent. There is evidence that many abusers of the elderly were themselves abused as children. Elder abuse also occurs in nursing homes and other institutional settings.

Suicide Risk requires a timely assessment. When someone is having suicidal thoughts, it is important to take the necessary steps to prevent harm. A “no harm” contract is often developed for those who are having suicidal ideation. If a client has a specific plan, it is important to have the client admitted to the hospital. If the client refuses to voluntarily admit him/herself into the hospital, it may be necessary to contact emergency services and a family member or friend to assist with the process.

DIAGNOSIS

The following is just a review of the DSM-IV TR. We recommend that you carefully study DSM-IV TR to gain a thorough understanding of assessment and diagnosis. **Do not utilize this summary to guide diagnosis in practice.**

DSM CLASSIFICATION SYSTEM

Multiaxial Classification - 5 Axes:

Axis I: Clinical Disorders (V Codes)

Other conditions that may be a focus of clinical attention

Axis II: Personality Disorders (V Codes)

Mental Retardation

Axis III: General Medical Conditions- current medical conditions that have potential relevance to the understanding/management of the disorders on Axis I or II

Axis IV: Psychosocial and Environmental Problems- This is the section in which you will list all psychosocial or environmental problems, such as marital problems or concerning financial conditions.

Axis V: Global Assessment of Functioning (GAF)- for reporting the clinician's judgment of the individual's overall level of functioning; useful in planning treatment and in measuring its impact; 0 – 100, followed by the time period, in parentheses; the higher the number, the better the functioning; zero indicates insufficient information to assess functioning level

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Specifiers Often Used to Rate Severity of a Clinical Disorder:

Mild: few, if any, symptoms in excess of those required to qualify for the diagnosis; only minor impairment in social/occupational functioning

Moderate: symptoms and functional impairment between “mild” and “severe”

Severe: many symptoms in excess of those required to qualify for the diagnosis; or several severe symptoms; or marked impairment in social or occupational functioning

In Partial Remission: the full criteria for the disorder were previously met; currently only some of the signs and symptoms remain.

In Full Remission: no longer any symptoms of the disorder

Prior History: no longer any symptoms of the disorder and the individual is considered as having made a full recovery

Example of a Multiaxial Diagnosis:

Axis I: 300.4 Dysthymic Disorder, Early Onset, With Atypical Features

Axis II: 301.6 Dependent Personality Disorder

Axis III: 244.9 Hypothyroidism, Acquired

Axis IV: Loss of close personal relationship

Axis V: GAF = 65 (current)

DISORDERS OFTEN DIAGNOSED IN INFANCY, CHILDHOOD OR ADOLESCENCE

Mental Retardation is characterized by significantly impaired general intellectual functioning, as measured by an I.Q. test, of 70 or less with significant impairment in adaptive skill areas (e.g., communication, interpersonal skills, work, recreation, self-direction); onset is by age 18 and is more common in males.

Degrees of severity:

- Mild (IQ of 50-55 to 70)

- Moderate (35-40 to 50-55)
- Severe (20-35 to 35-40)
- Profound (less than 20-25)

Learning Disorders are diagnosed when the individual's performance on tests designed to measure achievement in reading, mathematics, or written communication is significantly less than most others of the same age, educational level, and intelligence. The individual's performance has to significantly impair the individual's ability to perform activities of daily living or in the problematic academic area. Such disorders tend to be more common in males. Common categories of Learning Disorders include:

- **Reading Disorder**
- **Mathematics Disorder**
- **Disorder of Written Expression**

Motor Skills Disorder is the only motor skills disorder that is identified in DSM-IV. It is listed as **Developmental Coordination Disorder**. It is characterized by significant impairment in motor coordination needed to perform daily activities that is not the result of a medical condition or a Pervasive Developmental Disorder. If mental retardation is present, the impairment in motor coordination exceeds what is usually observed with this diagnosis.

Communication Disorders are identified in the DSM-IV under four areas. The communication difficulty must negatively impact academic or occupational achievement or interpersonal communication. These also tend to be more common in males.

- (1) **Expressive Language Disorder:** significant impairment in expressive (verbal or sign) language; evidenced by significantly lower scores on standardized tests of expressive language than would be predicted given the individual's nonverbal intellectual level and receptive language abilities
- (2) **Mixed Receptive-Expressive Disorder:** significant impairment in both expressive language and comprehension; evidenced by significantly lower scores on standardized tests of expressive and receptive language than would be predicted given the individual's nonverbal intellectual level
- (3) **Phonological Disorder:** significant impairment in ability to use age and dialect-appropriate speech sounds; interferes with the individual's achievement in academics or occupationally or with interpersonal communication
- (4) **Stuttering:** speech disturbance that involves impairment in fluency or timing of speech that is not age-related

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Pervasive Developmental Disorders vary in severity. Disorders that occur in early development are often more severe and involve serious impairment in social interaction skills, communication skills, or stereotypical (i.e., repetitive, nonfunctional) behavior, interests, and activities. These disorders frequently involve mental retardation. These disorders include:

Autistic Disorder is characterized by significant impairment in communication (e.g., inability and disinclination to communicate with others, idiosyncratic language, absence of age-appropriate imaginative/social imitative play) and social interaction (e.g., failure to form age-appropriate relationships with peers, apparent lack of interest in involvement with others, lack of reciprocity in social situations), as well as a very restricted range of interests and activities (e.g., repetitive performance of functionless routines/rituals, repetitive nonfunctional motions of parts of body). A therapist should consider this diagnosis after the client has been evaluated for Rhett's or Childhood Disintegrative Disorder. Autistic Disorder is more common in males than females.

Rhett's Disorder (also sometimes spelled "Rett") involves the development of a number of deficits including decelerated head growth, loss in hand skills, at least a temporary loss in social engagement, gait and trunk movement difficulties, severe psychomotor retardation, and severe disruption in expressive and receptive language development. The disorder occurs after a post-birth period of normal development and- until recently- has only been reported in females.

Childhood Disintegrative Disorder is characterized by significant loss of skills (e.g., expressive language, receptive language, social skills, control of bowel or bladder functions, play, motor skills) following a seemingly normal development during a period of at least two years post-birth. This disorder is more common in males.

Asperger's Disorder is distinguished by impairment in social interaction that is both severe and sustained. The individual has nonfunctional repetitive/stereotypical behaviors, interests, and activities in the absence of a significant delay in language, cognitive abilities, and the development of self-help skills. The individual has adaptive behavior that does not include social involvement and interest in the environment. This disorder is more common in males.

Attention-Deficit and Disruptive Behavior Disorders

Attention-Deficit/Hyperactivity Disorder has a clear pattern of inattention and/or hyperactivity not accounted for by an individual's developmental stage. Some symptoms are evident before age seven and impairment must be significant and evident in at least two different settings. There are three different types of ADHD: predominantly hyperactive, impulsive type, or inattentive combine type. ADHD is more common in males.

Conduct Disorder involves a pattern of violating the rules/norms of society and the rights of others in a variety of settings (e.g., may involve aggressive behavior with animals or people, the deliberate destruction of property, dishonesty, stealing, truancy, running away). If the onset is before the age of 10 it is called Childhood-Onset Type; onset at age 10 or later is called Adolescent-Onset Type. It is more common in males.