Mental health issues challenges of diagnosis and assessment psychology essay

The challenges of diagnosis and assessment are fundamental to the treatment of psychological disorders. There are a many issues raised by assessment, and its application. Many counsellors employ a number of different methods, such as pre-counselling interviews, intake questionnaires or diagnostic testing. Counsellors may also consider assessment according to their own theoretical model or counselling approach.

Clinical assessment is the process of evaluating and measuring psychological, biological, and social factors in an individual presenting with a possible mental disorder. Information and data gathered from examinations, interviews, assessments and medical history are evaluated, and an assessment, then prognosis and treatment can be formulated.

For counsellors and other allied health professionals, there are a variety of diagnostic models available, that often take into account different counselling theories and approaches. For the purpose of this assessment, the diagnostic medical model will be discussed in comparison to a diagnostic biopsychosocial model, and their uses in working with mental health issues.

Diagnosis is the process of determining whether the particular problem affecting the individual meets all criteria for a psychological disorder (American Psychiatric Association, 2000). The medical model is based on a set of norms that views behavioural abnormalities in the same framework as physical disease or abnormalities. An assessment using the medical model may consist of interviews, and behavioural assessment and testing, such as personality inventories or intelligence tests

It deals primarily with medical diagnoses: DSM-IV is the latest incarnation of the “ Diagnostic and Statistical Manual” produced to assist in making clear, correct, and reliable diagnoses, and promote more accurate knowledge about mental disorders (Barlow & Durand, 2008).

One of the most useful and valuable functions of the DSM-IV is that is provides a framework for clinical practice, a common system of naming and describing mental disorders. This common framework not only provides shared terms allowing easy information sharing and use of research among mental health professionals, but also facilitates sharing of diagnoses with clients and other practioners, and simplifies the recording and dissemination of records and cases.

The DSM-IV also assists mental health professionals to anticipate the typical course of a disorder and the client’s symptoms, to support the development of treatment plans.

The DSM-IV classifies and mental disorders into divisions based on set criteria. This categorisation is the fundamental approach used in all systems of medical diagnosis (American Psychiatric Association, 2000). This model works best when all members of a set or class are uniform, when there are clear boundaries between classes, and when the different classes are mutually exclusive. Unfortunately, not all people present with standard symptoms or problems. Many mental disorders are not distinct disorders, but will appear with others (for example, depression is often seen with other mental illnesses, and insomnia may be a symptom of something else, rather than a final diagnosis). The DSM-IV also mirrors social attitudes about just

what is defined as a mental disorders, and what they are comprised of. Just looking at the changes in the last few decades on the treatment of homosexuality by the DSM-IV, where it has moved from being classed as a mental disorder, to not being included, heightens the idea that these are guidelines, and should be treated with responsibility, accountability and due care.

The DSM-IV useful in situations where a formal classification of mental health disorder may be required, due to legislative or judicial requirements (Bernstein & Nash, 2006). For example, a child may be eligible for government financial assistance if a particular disorder is diagnosed using a DSM-IV classification, or other diagnoses may mean that educational institutions or government agencies such as the Public Trustee take action or use different processing criteria in dealing with clients. The acceptance of DSM-IV classifications by government agencies, insurance companies and medical institutions means there are common backgrounds and settings, allowing smooth communication and interaction.

While acknowledging that the medical model is extremely useful, it is not without its drawbacks. There is the risk that a relatively small number of instances can form attitudes and influence legislation. As previously mentioned, the DSM-IV is very culturalcentric, and it is very strongly based on disorders and conditions as they present in the USA, and westernised, first world countries, there may not be as relevant or useful in different countries, cultures or sub-cultures (Barlow & Durand, 2008).

As the medical model is very much concerned with labels and classification, it can also be very demoralising to be reduced to a label or to be pigeonholed, and can lead to negative perceptions by the client, and towards the client (Bernstein & Nash, 2006).

There is also the danger that the very linear approach to diagnosis can prevent a more holistic and progressive understanding of the client. The categorising and classification of the client may also overemphasise, and focus on the client, rather than on their family or social system, where the problem or resolution might be (Barlow & Durand, 2008).

The diagnostic medical model is based on deficiencies and negative comparisons to normal mental functioning, rather than identifying positive attributes, traits or factors. It involves assessments by third parties who usually do not know the client very well, but look at and quantify the client’s departure from the norm, and can be responsible for many negative connotations.

It has also been suggested that modern medical thought was governed by the perception that human mind and body can be treated by introducing chemical compounds into the mechanical system of the body, and by repairing or replacing parts. This thinking excluded the psychological and spiritual aspect of treating humans, and considered biological factors of primary importance overlooking factors as the patient’s psychological, culture or social environment (Hewa & Hetherington, 1995)

It is this exclusion that led George Engel propose a more inclusive, alternative model, and to include a sociocultural and psychological

framework to the limited biological framework of the medical model. This model assumes that psychological and social factors must also be included along with the biological to gain a real understanding a person's medical illness or disorder (Bernstein & Nash, 2006).

It is quite an integrative and comprehensive model that allows us to focus on the presenting issue across three spheres: physical, psychological, and sociocultural. Proposed by Engel in the 1979's, it allows and encourages health professionals to holistically examine the interactive and reciprocal effects of environment, genetics, and behaviour (Engel, 1977).

As an alternative to the medical model, this approach is used not just as a diagnostic system, like the DSM-IV, but as a tool to collect data to gain information about the client and their environment, to aid the planning of successful treatment (Cormier, Nurius, & Osborn, 2008, p. 1760).

Instead of just a breakdown of symptoms, or reports by treating professional or third parties, more unclassified or unquantifiable factors can be taken into account; individual responsibility or personal determination can be considered, or particular outlooks and insights can highlight emotional difficulties and strengths, allow alternative and personalised treatment. In helping clients coping with gambling or drug addiction, this could be a definite advantage. A client's behaviour, their mood and thought processes is a major influence in the success or failure of any treatment plan (Engel, 1977).

Attention is paid to how a client functions in everyday life, how they manage social roles, emotional stability, intellectual capacity and overall well-being (Bernstein & Nash, 2006).

This model also acknowledges the importance of social areas, including family systems, diversity, and social justice (Kaplan, 2005). Assessment that includes an understanding of support structures such as friends, family or advocates, and access to medical care or continued case management, is more like to produce long term, positive results.

Treatment wise, the biopsychosocial model seems to be a far more holistic approach, and better suited to help the whole person, rather than simply focusing on a particular disorder.

Drawbacks to this module may be that it is very subjective and individual, making its use more difficult for organisations that are funded or staffed based on the classification of their clientele. This model would also use up much more of a counsellor’s time as the medical model, again making it less cost effective, especially for government or not-for-profit organisations. The individual and personal nature of this model makes its funding and resourcing much more difficult than the more general medical model (Bernstein & Nash, 2006). Overall, it seems to be a more positive model, leading to better results. Both models presume that trained professionals will be using these assessment tools, and both models will not function well if not used with appropriate training and attention. In the short term, the medical model would be cheaper to fund, but long term the biopsychosocial model should produce longer lasting and better outcomes (Engel, 1977).

Assessment is the systematic evaluation and measurement of psychological, biological, and social factors within an individual (Barlow & Durand, 2008). Diagnosis is the process of determining that those factors meet all the criteria for a specific psychological disorder. The subsequent step, to consider how this information be used to assist people to live rich and meaningful lives, is where the biopsychosocial model is able to provide more material and information to assist clients and mental health workers.

The aim of counselling is to be of help and assistance to the client, to aid in living better lives, coping with various situations, and develop and progress as human beings. Categorising and classifying disorders does make life easier for an assessment, but every situation is different, and every client is unique and individual.

It not always a one size fits all treatment. A good counsellor should consider the question presented by Gordon Paul – " What treatment, by whom, is most effective for this individual with that specific problem and under which set of circumstances?" (Kaplan, 2005, p. 1). Counselling requires a comprehensive inclusive model that allows assessment and intervention across the variety of methods and approaches.

A sound diagnosis is a starting point for a treatment plan, not necessarily an end to itself. The DSM-IV is indispensable in providing a common framework for practioners and researchers. However, it is the start of the process, and is also in a constant state of change as ideas change, research continues, and our knowledge of mental health disorders increases.

The more that a problem can be understood, a more reliable and helpful action can be planned. The more holistic biopsychosocial model, taking into account more areas of the client's life, environment and spheres, provides a clearer picture of the client's circumstances, and any mechanisms that are available to help the client cope with problems and difficult situations.

For the person-centred counselling approach, the attitude towards assessment, diagnosis and treatment are seen as compromising " genuineness" – a fundamental element of the person-centred approach.

To the Rogerian perspective, how the client is assessed by the counsellor is not as important as the client assesses themselves. " The opportunities for new learning are maximised when we approach the individual without a preconceived set of categories which we expect him to fit" (Rogers, 1965, p. 497). The client is the one with the potential to know, understand, and change their feelings and behaviours, and to harness support networks to change themselves.

According to Rogers, diagnosis in itself could be unwise, as the focus of assessment shifts to the counsellor as an expert, dependent tendencies may develop. Considerations of such a nature have led person-centred therapists to minimise the diagnostic process as a basis for therapy (Cormier, Nurius, & Osborn, 2008).

This is reflected by Egan, with the statement that " assessment, then, is not something helpers do to clients...Rather, it is a kind of learning in which, ideally, both client and helper participate" (Egan, 2007)

In keeping with the need for greater client involvement, humanistic oriented counsellors often employ more qualitative (how and why) methods of assessment where the client participates actively in learning/assessment exercises integrated into the counselling sessions themselves, rather than the more quantifiable (what and when) assessment associated with the medical model and the DSM-IV.

The model’s inclusive, multi-factorial or holistic advantages create the possibility of an approach to mental health problems, which could be both scientific and humanistic.

As a diagnostic tool for helping people with mental disorders, the biopsychosocial model would be suited than a strict medical model as we understand that mental illness arises from more than biological factors, look at body, mind, spirit, relationships and environment, in treating a human individual, not merely treating an illness.

As George Engel wrote;” nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to health care” (Engel, 1977, p. 135)