

Pedagogical Strategies for Teaching the *DSM*: Centering Diversity and Equity

Amy Levine
Marilyn Ghezzi

Abstract: *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition presents numerous ethical challenges for social workers. As social work educators, we are tasked with preparing students for clinical social work practice, which includes not only instructing students in the use of the DSM-5, but also emphasizing the importance of pursuing social justice and equity in clinical work. With the most recent revision, the DSM-5 Task Force attempted to improve cultural awareness and sensitivity – efforts that yielded mixed results. This article explores the changes, benefits, and shortcomings of these efforts to address cultural diversity and highlights pedagogical approaches for bringing this knowledge to the MSW classroom. We describe specific teaching strategies that underscore the importance of a strong cultural formulation of client problems and are designed to inspire critical thinking about the process of diagnosing. Social workers are encouraged to adopt these strategies for using the DSM-5 not only to better inform their clinical decision-making but also to better align their clinical practice with social work values and ethics.*

Keywords: *Clinical social work practice, social work pedagogy, cultural awareness, DSM-5*

Social Work and *DSM-5*: Central Tensions

In the 70 years since the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*, American Psychiatric Association [APA], 1952), social workers have had a conflicted relationship with the manual. In their practice, clinical social workers must expertly use the manual to accurately assess clients' mental health and choose appropriate evidence-based interventions when needed. However, this process is hampered by the serious shortcomings in the *DSM's* framework and perspective on mental illness. Despite the challenges, the *DSM* facilitates clear communication among professionals by providing a common language for mental health conditions. The manual has undergone periodic revisions to incorporate new research findings (McQuaide, 1999; Petrovich & Garcia, 2016). For some clients, receiving a diagnostic label can be validating and is often necessary to receive access to interventions that address their mental health challenges as well as for providers to receive reimbursement (Sutherland et al., 2016). Further, a diagnosis can enable clients to name, externalize, and better understand sources of great distress in their lives (Craddock & Mynors-Wallis, 2014).

Despite these benefits, the *DSM* is a manual primarily designed by and for psychiatrists, and its medical model approach to diagnosis conflicts with social work values and ethics in several important ways. In her seminal article, McQuaide (1999) summarized

Amy Levine, MSW, LCSW, Clinical Assistant Professor, and Marilyn Ghezzi, MSW, LCSW, Clinical Associate Professor, School of Social Work, University of North Carolina, Chapel Hill, NC.

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social workers' concerns about the *DSM*'s focus on pathology rather than strengths, its lack of person-in-environment perspective, its lack of cultural sensitivity, and its reliance on the medical model as the basis for diagnosing mental illness. These critiques remain relevant even after the *DSM*'s most recent fifth edition (*DSM-5*; APA, 2013). Moreover, numerous scholars have echoed the limitations of the current system of diagnostic classification as having limited utility, which led to recent efforts by the National Institute of Mental Health to consider new systems of diagnostic classification (Bredstrom, 2019; Insel, 2014; Kozak & Cuthbert, 2016; Petrovich & Garcia, 2016; Sutherland et al., 2016; Thornton, 2017). To build greater critical consciousness regarding the history and function of *DSM* in our society, Karter and Kamens (2019) urged clinicians to apply an ecological framework to the process of diagnosis. Their call expands Sutherland and colleagues' (2016) discussion that noted *DSM* diagnoses frame client distress as purely personal, which not only can increase shame and stigma but also downplay the relational and sociopolitical dynamics that impact clients' symptoms. By contrast, a hallmark of clinical social work pedagogy is ensuring students understand the ways in which diagnostic labels can affect a client's sense of self (Peter & Jungbauer, 2019). Social workers using the *DSM-5* must be critically aware of the manual's shortcomings and understand how to align social work values and ethics with the process of diagnosing mental illness. Although the diagnostic process is only one aspect of case conceptualization, the use of the *DSM-5* is central to many clinical roles across social work settings. As such, social work educators have the responsibility of establishing a learning environment in which students can learn these critical thinking skills and understand how to apply the insight gained to the diagnostic process in their practice. This article focuses solely on the changes in the *DSM-5* regarding cultural issues and the implications of these changes for social work education.

Changes in *DSM-5*: Improvements or Window Dressing?

With the 2013 publication of *DSM-5*, the APA made some significant shifts, including abandoning the multiaxial diagnostic system that many clinicians viewed as central to highlighting the potential impact of environmental and contextual factors on an individual's functioning (Walsh, 2016). The APA made several explicit attempts to improve the cultural sensitivity in the *DSM-5*, including adding a section to most diagnostic categories that addresses cultural factors, developing the Cultural Formulation Interview (CFI), and adding a glossary of cultural concepts of distress to the Appendix (APA, 2013; Lewis-Fernández & Aggarwal, 2013). The introduction to the *DSM-5* summarizes various ways that culture can impact diagnosis, including how distress is communicated in different cultures and how culture shapes an individual's understanding of their illness (APA, 2013).

The CFI and its accompanying handbook provide guidance to clinicians about how to integrate ethnographic interviewing into standard psychiatric assessment (Lewis-Fernández et al., 2016). For example, one of the initial questions in the CFI directs the clinician to ask the client to describe their problem as they would explain it to their family, friends, or others in their community (APA, 2013). This line of questioning attempts to decenter the clinician's conceptualization of the problem and invites the client to share their lived experience. Subsequent CFI items prompt the clinician to ask whether any aspects of the client's identity impact the problem they are experiencing. The client is encouraged to

share ways they have already attempted to cope with their problem, including consulting healers or helpers from within their community (APA, 2013). The focus of this questioning further supports the client in expressing a holistic understanding of their current challenges, coping strategies, and functioning that can be particularly useful in making a culturally-informed diagnosis (Jarvis et al., 2020). Encouragingly, field studies designed to assess the implementation of CFI in clinical practice in six countries concluded both clients and clinicians found the tool “feasible, acceptable and clinically useful” (Lewis-Fernández et al., 2017, p. 295). These important additions have enhanced and nuanced the *DSM-5*’s conceptualizations of culture, mental illness, and the diagnostic process.

Since the *DSM-5*’s publication in 2013, researchers’ have given mixed reviews of the changes intended to boost the manual’s cultural sensitivity (Bredstrom, 2019; Petrovich & Garcia, 2016; Sutherland et al., 2016; Thornton, 2017). Paniagua (2018) noted the *DSM-5* has taken far greater steps toward centering cultural diversity than the World Health Organization’s (WHO) *International Classification of Diseases*, the global diagnostic classification standard that has far fewer cultural guidelines (WHO, 2021). However, other authors noted the failure of the *DSM-5* to fulfill the promise in its introduction to integrate cultural factors throughout the manual. Indeed, the *DSM-5* lists of diagnostic criteria fail to integrate cultural factors. For example, cultural concepts of distress remain relegated to the Appendix (Bredstrom, 2019; Paniagua, 2018; Thornton, 2017). Even though additions such as the CFI can be useful tools in promoting a culturally-informed diagnostic process, this assessment tool is not well-integrated into the primary body of the manual; therefore, clinicians might not consider incorporating additional assessments as an essential part of the diagnostic process (Aggarwal et al., 2013). Many researchers and clinicians have reported the *DSM-5* remains ethnocentric given that cultural aspects are emphasized for non-Western cultures but not for socially dominant cultural groups (Bredstrom, 2019; Thornton, 2017). Bredstrom (2019) concluded that throughout the manual, the *DSM-5* fails to recognize cultural diversity and psychosocial contexts, noting “context within *DSM-5* [sic] becomes an ethnic dividing line between those who are seen as culturally ‘other’ and those who are not” (p. 361). Therefore, social work educators have an imperative not only to teach *DSM-5* diagnostic criteria but also to highlight important critiques of the manual and explore the ways in which the strengths and weaknesses of the *DSM-5* impact assessment in practice.

Strategies for Teaching *DSM-5* in Social Work Education

Given that social workers are becoming the predominant providers of psychotherapy, the ethical tensions clinical social workers face are increasingly discomfiting. Phillips (2013) focused on this discomfort by asking, “So what are clinical social workers to do, working in a system which they did not create, which, in many ways, is antithetical to their values and beliefs, and which raises a number of new responsibilities and potential liabilities?” (p. 211). Social work educators are tasked with preparing students to use imperfect tools—such as the *DSM-5*—and to work within imperfect systems to treat, support, and advocate for their clients. Thus, the central question is how to teach social work students about making clinical assessments using the *DSM-5* in a way that refrains from pathologizing human experiences and replicating inequitable power dynamics, but

instead reinforces diversity, equity, and inclusion. To help answer this question, we present strategies to help social work instructors achieve this balance in training future clinicians.

Sociocultural Context of Assessment and Diagnosis

Social work educators can begin achieving a balanced clinical perspective in their courses by ensuring students understand the significance of sociocultural context for a given diagnosis. As a discipline, social work emphasizes an individual's lived experience is influenced through their culture, identities, relationships, challenges, hopes, and strengths. A central pedagogical goal of the field is to encourage students to consider the ways in which these factors affect an individual's adaptive functioning. In this regard, it is important for social work courses to examine the ways in which individual, institutional, and cultural racism and other manifestations of oppression can negatively impact an individual's physical and mental well-being (Jones & Neblett, 2019). In every reading, case study, or class activity, instructors can raise questions about the ways in which experiences of oppression—especially when coupled with other personal, relational, and sociopolitical dynamics—can contribute to changes and challenges in an individual's thought patterns, moods, behaviors, and current functioning. Additionally, instructors can highlight the limitations of the *DSM-5* by demonstrating the ways the manual's diagnostic criteria fail to meaningfully acknowledge many sociocultural factors.

Another classroom strategy is to encourage students to examine the ways a diagnosis might further pathologize individuals and reproduce societal power differentials. Petrovich and Garcia (2016) focused on this issue in their exploration of the harmful impact of misdiagnosis. As one solution to the problem, these authors proposed a “diversity/resiliency formulation” that acknowledges a client's resources and strengths while highlighting the sociocultural elements that might affect the client's overall functioning. Instructors can use this diversity/resiliency framework to highlight shortcomings of *DSM-5* and discuss alternative diagnostic considerations with potential to yield more effective and ethical practice. Additionally, incorporating contemporary events (e.g., fear of deportation, anti-transgender legislation, police violence) in class content alongside discussions of specific diagnoses can encourage students to consider the way in which current social issues can directly impact the mental health of individuals and communities (Becerra, 2016; DeVylder et al., 2020; Seelman, 2016). By bringing real-world examples into discussions of the diagnostic process, instructors can underscore the importance of incorporating culturally-informed biopsychosocial assessments in making an accurate diagnosis that demonstrates an awareness of the individual's relationship to their current environment.

Critical Reflection on Diagnostic Labels

Beyond highlighting the importance of sociocultural contexts in conducting an assessment, students can be encouraged to critically reflect on the ways diagnostic labels can affect an individual's sense of self. For example, instructors might ask students to share their perspectives on positive and negative aspects of mental health diagnoses, and then facilitate discussions about the multiple, varied ways a diagnosis can impact individuals based on elements of the individuals' unique identities, personal histories, access to needed

services, and a multitude of other factors. For instance, instructors could provide discussion prompts such as, “What might be the benefits of being diagnosed with a particular disorder?” “Have you worked with clients who found the label helpful or reassuring?” “What are the possible negative impacts of diagnosis on our clients?” “How might you feel if you were told you had a particular diagnosis?” These questions also help students to clarify their own values and recognize biases held about particular diagnoses as well as the act of diagnosing.

The evolution of the *DSM* is compelling, from its biological origins focused on neurological illnesses, to the strong influence of psychoanalytic theory, to the data-driven medical model of diagnostic criteria. Over time, the purpose of the manual has shifted from gathering prevalence data to functioning as the primary mode of monetary reimbursement for clinical practice (Surís et al., 2016). In the classroom, an analysis of the *DSM* history that underscores its changing theoretical bases as well as its lack of cultural awareness will help students understand the manual’s historical context and the subjectivity of the content. Additionally, instructors can highlight the significance and meaning of mental illness across sociocultural contexts by exploring global conceptions of mental health. The evolving field of global mental health (e.g., Collins, 2020; Patel & Prince, 2010; Watters, 2010) can encourage students to examine culturally diverse narratives about health and healing, and thereby, develop a better understanding of the ways mental well-being and mental illness are conceptualized from non-Western perspectives.

Classroom instructors can delve into the “how to” of assessing a client’s mental health by emphasizing how discussing their findings (i.e., their diagnosis) with the client can provide an opportunity to explore the impact of cultural dynamics on the client’s functioning and experience of mental health symptoms. Instead of using a diagnostic label as something that further individualizes, medicalizes, or pathologizes the client, the clinician can approach these discussions in a way that invites a critical conversation with the client about how culture, power, and privilege can directly affect their experience of mental health symptoms (Sutherland et al., 2016). As a pedagogical strategy, instructors can present a clinical vignette and ask students to role-play delivering this diagnosis to their client. In the role-play, students can practice providing psychoeducation about the assessment and treatment while strengthening their ability to process a client’s reactions and questions about the diagnosis in a way that validates the client’s identity and experience. Clinical case studies and vignettes can easily be accessed through resources produced by the APA (Barnhill, 2014). By incorporating these role-plays into the classroom and emphasizing the ways such discussions can ultimately serve to empower the client, instructors can better prepare students for difficult and critical conversations with clients.

Impact of Clinician Bias

Instructors can help students become self-aware clinicians by using pedagogical strategies that address the impact of clinician bias and lack of cultural humility on the diagnostic process. In the classroom, instructors can illustrate this point via an in-depth examination of the relationship of specific diagnoses to culture and identity. For instance, oppositional defiant disorder (ODD) is a highly stigmatized diagnosis that often sets a

negative trajectory for children and adolescents. Although epidemiological studies have shown that African American and White children have similar rates of ODD behaviors, African American youth, particularly males, are more likely to be diagnosed with ODD than White youth (Ballentine, 2019; Grimmert et al., 2016). Multiple scholars have noted this overdiagnosis of ODD requires a multi-layered explanation and stems not only from the problematic biases of the ODD criteria in the *DSM* but also from stereotypes of African American male youth as aggressive, hostile, and violent (Ballentine, 2019; Fadus et al., 2020). Additionally, clinicians might misinterpret a client's behavior as symptoms of other disorders or syndromes (e.g., attention deficit hyperactivity disorder [ADHD]) or as irritability or defiance, which are key diagnostic criteria for ODD. Not surprisingly, this combination of personal assumptions, biases, and failure to acknowledge other contributing factors (e.g., psychosocial stressors, structural racism, or a history of trauma) is likely to lead clinicians to make an inaccurate ODD diagnosis that stigmatizes young clients.

Social work instructors can highlight the research on misdiagnosis and apply insights to a range of evidence-based case examples, including overdiagnosis of schizophrenia spectrum disorders in African American and Latinx populations, underdiagnosis of autism spectrum disorders in females, and underdiagnosis of attention deficit hyperactivity disorder in African American and Latinx populations as well as females of all races/ethnicities (Morgan et al., 2013; Quinn & Madhoo, 2014; Ratto et al., 2018; Schwartz et al., 2019; Schwartz & Blankenship, 2014). As the instructor teaches students about the *DSM-5* diagnostic categories, their lessons can openly and regularly explore questions about which clients do and do not receive these diagnoses, and the propensity of clinicians to overdiagnosis disorders in certain populations. The information and insight gained from these discussions are important for social workers to consider in their practice. Such critical questioning will encourage students to move beyond rote memorization of diagnostic criteria to a deeper understanding of how diagnostic decisions play out in the real-world with significant ethical and social justice implications.

Tools for Diagnostic Formulation

Another pedagogical strategy is to teach students to use existing tools that can help them consider cultural and identity factors in the assessment process. When used appropriately, the CFI provides a useful guide for strengthening students' diagnostic skills in this regard. In class, instructors can lead discussions about the utility of the CFI in the context of changes to *DSM-5*. Students can then apply the tool in class activities to practice assessing how a client's cultural identity, associated cultural factors, and the relationship dynamics between client and clinician may contribute to the diagnostic process (APA, 2013). Instructors can also direct students to the APA's *DSM-5* website where students can view videos of clinicians using the CFI during client assessments (APA, 2013). As case studies are presented, students can discuss how using the CFI could enable them to better understand the client's perspective, current functioning, and presenting symptoms (Lewis-Fernandez et al., 2016).

Reviewing the other culture-related additions in *DSM-5* (e.g., Glossary of Cultural

Concepts of Distress and Culture-Related Diagnostic Issues sections) and learning how to effectively use this information when making client assessments is an important skill for students to develop (APA, 2013). As part of class discussions of case studies and activities, instructors can reference the *DSM-5* additions to highlight the specific cultural issues pertinent to social workers' assessments. To mitigate bias and to ensure students consult multiple sources of information, instructors should encourage students to incorporate structured interviews and standardized assessment tools into the assessment process. Instructors should discuss the cultural validity of assessment scales and provide examples of adaptations to scales that better address specific cultural needs (e.g., Depression Self-Rating Scale and Child PTSD Symptom Scale; Kaiser et al., 2019; Kohrt et al., 2011). The overall goal is for instructors to show students how and why to thoughtfully consider cultural factors when assessing a client's current functioning and symptom presentation using multiple methods to arrive at an ethical and accurate diagnosis.

Clinician Bias and the Role of Advocacy

Instructors must convey to students not only the need to continually examine their own implicit biases but also their responsibility to continuously advocate for needed systemic change within the world of mental health treatment to foster more inclusive and equitable treatment paradigms (Schwartz et al., 2019). Numerous studies have confirmed the relationship between the clinician and the client is the most salient factor in a client's successful engagement in mental health services and positive outcomes (DeAngelis, 2019; Flückiger et al., 2018; Shattock et al., 2018). Instructors can highlight the value of cultural humility in engaging clients and providing culturally-informed comprehensive assessments, accurate diagnoses, and effective mental health treatment through a strong therapeutic alliance (Gottlieb, 2021; Lekas et al., 2020). Challenging students to identify their preconceptions about specific diagnoses as they learn about *DSM-5* diagnostic criteria and using materials throughout the course that center the voices and experiences of people living with mental illness will enable students to learn from and not just about clients.

To promote bottom-up systemic change, instructors might encourage students to submit their critical assessments of problematic content in the *DSM-5* to the APA via the section of the APA website that invites feedback on the manual. Instructors can also present additional opportunities for students to advocate for needed changes in mental health services and delivery of care. Moreover, instructors should make clear the connections that exist between *DSM-5* misdiagnoses and social problems such as the school-to-prison pipeline, homelessness, and mass incarceration. For example, when noting the underdiagnosis and treatment of ADHD in children of color and the ways underdiagnosis can affect behavior, academic success, and self-esteem, instructors can clarify the ways a misdiagnosis (or a missed diagnosis) can impact the trajectory of an individual's life course (Moody, 2016; Shi et al., 2021). Classroom discussions provide students opportunities to explore macro-level factors that contribute to mental health disparities, such as a lack of access to culturally-relevant interventions and lack of health insurance. Additional advocacy efforts could include examining alternatives to *DSM-5* as the primary system for clinical reimbursement and urge greater attention be given to developing more holistic and culturally-informed assessments of an individual's functioning and needs within their

community (Raskin, 2019). Last, social work educators must call attention to the immense power clinicians hold when assessing mental illness. Educators must explore the weight of this responsibility with students and carefully examine the complexities of promoting ethical practice at the individual, community, and system levels.

Conclusion

To promote ethical practice, social workers must approach assessment of mental health and functioning in a way that supports and empowers clients instead of relying on methods and materials that can contribute to clients' marginalization and oppression (Petrovich & Garcia, 2016). Given the high stakes for client outcomes, social work educators have a responsibility to teach students to critically examine their assessment practices. This pedagogy requires instructors to underscore the problematic history and current critiques of the *DSM-5* while giving students practical strategies for assessing mental health needs within a cultural context and providing culturally-informed, accurate, and ethical assessments. Social work educators can also foreground possible tensions between the field's Code of Ethics (National Association of Social Workers, 2021) and using *DSM-5* criteria to provide a mental health diagnosis. Ultimately, educators must assist students, as well as the social work profession, in advancing an understanding of mental health assessment and intervention that is inclusive and equitable for all.

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Author note: Address correspondence to Amy Levine, School of Social Work, University of North Carolina at Chapel Hill, Campus Box 3550, 325 Pittsboro St, Chapel Hill, NC 27599. Email: amylevine@unc.edu