

# DSM V For CLINICIANS

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## Introduction

- **Field of Psychiatry is not an exact science**
- **Mankind has always tried to understand people's actions and reactions.**
- **Explained in the past as possession and witchcraft**
- **Psychiatry is a new science less than 100 years old**
- **Grew out of the medical field – there are certain biological differences between men.**
- **There was a need to develop a universal language**
- **The DSM became the means of communication and conceptualization of psychiatric illness.**

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## DSM V Status

- **13 workgroups began in 2007 with no predetermined limit on the change they could recommend.**
- **Based on this comprehensive review of scientific advancements, targeted research analyses, and clinical expertise, the work groups will develop draft *DSM-V* diagnostic criteria.**
- **The work groups will develop draft *DSM-V* diagnostic criteria. A period of comment will follow.**

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## DSM V Status

- The final criteria will be revised and the final draft of *DSM-V* will be submitted to the APA's council on research, assembly, and board of trustees for their review and approval. A release of the final, approved *DSM-V* is expected in may 2012.
- *DSM-5* is based on the suggestion that it will be introducing 30 or more dimensional ratings and that this will increase the precision of diagnosis. The dimensional components already built into the *DSM* system (i.E.,Severity ratings of mild, moderate, and severe for every disorder and the axis V global assessment of functioning scale) are very often ignored.

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## DSM V Status

- A second, related category of innovation would be to include as defined mental disorders "prodromal" forms of the schizophrenic, mood, dementia and perhaps other disorders. This again has the obvious appeal of promoting early case finding and preventive treatment. For example, they may be adding a new "pre-psychotic" category for individuals supposedly at high risk for later developing a psychotic disorder.
- A third category of *DSM-V* innovation would create a whole new series of so-called "behavioral addictions" to shopping, sex, food, videogames, the Internet, and so on.

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## Risky Potential Changes

- (A) adult attention-deficit/hyperactivity disorder(ADHD) (b) adult separation anxiety disorder;
- (C) making it easier to diagnose bipolar disorder;
- Pediatric bipolar,
- (D) pediatric major depressive, and trauma disorders;
- (E) autism spectrum disorders;
- (F) new types of paraphilias and hypersexuality disorder; (G) a suggested rating list to evaluate suicidality.
- (G) Inclusion of Psychological Testing Criteria Sets
- It is suggested by the American journal of psychiatry that suicidal behavior be considered a separate diagnostic category and provide an axis just for it.

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## 7 Main Philosophical Changes

- No clear difference between a medical illness and a psychiatric one.
- Most normal people have personality defects.
- People have illnesses they aren't illnesses.
- There are many different looks to each disorder.
- Conduct disorder and antisocial disorder should be on the same axis.
- Childhood personality must be considered.
- *Cultural variants in symptom definition and symptom manifestations.*

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## DSM V - 5 Axes

- **AXIS 1 (19 Diagnostic Categories)**  
Clinical Disorders & Other Disorders That May Be the Focus of Clinical Assessment
- Disorders Diagnosed During Infancy      Mood Disorders
- Delirium, Dementia, Amnesic/Cognitive      Anxiety Disorders
- Substance Related Disorders      Somatoform Disorders
- Schizophrenia & Other Psychotic Disorders      Factitious Disorders
- Sexual & Gender Identity Disorders      Dissociative Disorders
- Eating Disorders      Sleep Disorders
- Impulse Disorders Not Elsewhere Classified      Behavioral Addictions
- Adjustment Disorders      Developmental D/Os
- Relational Disorders      Autism Disorders
- Other Disorders that May Be a Focus of Clinical Attention

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## Axis 1- Acute & Mediatable Disorders

- Must make a differential diagnosis.
- Usually considered the primary d/o unless otherwise specified.
- Can have multiple diagnoses on axis 1.
- The first one listed considered primary.
- If no axis 1 disorder then axis 2 principal.
- If both axis 1 & 2, 1 is the principal unless otherwise stated.

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## Axis 1 Changes

- **New Behavioral Addictions Category – Internet, Sex,**
- **Deleting Aspergers Disorder-evidence suggests that Asperger's and High Functioning Autism do not represent distinct disorders: they co-occur.**
- **Delete Pervasive Developmental Disorder.**

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## Axis 1 Changes

- **Merge Aspergers and PDD into a High Functioning Autism Disorder with 2 types:-** Type I would be for prototypical cases characterized by problems in social interaction, social communication, and repetitive behaviors or preoccupations, and Type II is for atypical cases.
- **New Relational Disorder** Relational disorders involve two or more individuals and a disordered "junction," whereas typical Axis I psychopathology describes a disorder at the **individual** level. An additional criterion for a relational disorder is that the disorder cannot be due solely to a problem in one member of the **relationship**, but requires pathological interaction from each of the individuals involved in the relationship. Example next slide.

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## Axis 1 Changes

- **For example, if a parent is withdrawn from one child but not another, the **dysfunction** could be attributed to a relational disorder. In contrast, if a parent is withdrawn from both children, the dysfunction may be more appropriately attributable to a disorder at the individual level.**
- **The proposed new diagnosis defines a relational disorder as "persistent and painful patterns of feelings, behaviors, and perceptions" among two or more people in an important personal relationship, such a husband and wife, or a parent and children**

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## Kinds of relational disorder

- Marital relational disorders
- Parent-child abuse disorder
- Domestic Violence Disorder
- Stalking Disorder

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## Axis 2 Chronic & Enduring Disorders

### AXIS 2

- **Personality Disorders & Mental Retardation**
- **PARANOID**                    **DEPENDENT**
- **SCHIZOID**                    **OBSESSIVE COMPULSIVE**
- **ANTISOCIAL**                **DEPRESSIVE**
- **HISTRIONIC**                **NARCISSISTIC**
- **AVOIDANT**                **Passive Aggressive**
- **BORDERLINE**-Hysterical/Dysphoric, Schizotypal, Angry Impulsive.
- **Traumatic**
- **PERS. DISORDER NOS**
- Biological indicators or genetic connections included.

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## Axis 3 Medical Conditions

- List all medical conditions – from hemorrhoids to hangnails.
- If a disorder is due to a general medical condition list it on axis 3 and axis 1  
ie. Major depression due to diabetes  
diabetes on axis 3
- If axis 3 not related to another axis then only axis 3.
- If more than 1 axis 3 then list all of them.
- If the medical disorder causes a psychological reaction list both ie. Cancer and Depression

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## Axis 5 – 3 scores

- Score 1 – the optimal level of functioning the last 12-24 months
- Score 2 – The axis 5 score at the time of admission
- Score 3 – Every session thereafter.
- The score should go up over time towards the previous optimal level of functioning.
- Concerns about inter rater reliability of the GAF led to development of the Modified GAF, which included descriptive anchors to increase reliability of GAF rating
- DeChello's Theory of Psychoeconomics

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## Directions for the M-GAF

- When the symptom severity and the level of functioning are not in accord, the MGAF score should be based on the client's lowest level of functioning.
- There are 6 Steps to creating an M-GAF score

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## Directions for the M-GAF

- Step 1 – the Assessment
- Step 2 – the GAF Worksheet (See Handout)
- Step 3 – Start at the top or bottom of the MGAF and read the criteria in each 10 point interval on the form asking yourself is my client's severity or level of functioning listed in this section worse or better than what is indicated in this section.

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## Directions for the M-GAF

- STEP 4 Look at the next higher or lower range and ask yourself is my client's level of functioning better or worse until you arrive at an interval where the client does not fit better.
- STEP 5 Read the scoring criteria in the box to the right of the 10 point interval you have chosen and use the guide to determine the score.
- STEP 6 – Do this 3 times, once for the past 12 –24 months, once for date of admission and once for every subsequent session.

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## Directions for the M-GAF

- It is critical that the scores you choose are based on the client's lowest level of functioning.
- Treatment should be based on the client's level of functioning.

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## M-GAF Scores should be used to guide the level of care.

### EXAMPLES:

**Scores of 71+** -considered normal functioning  
insurance usually stops paying.

**Scores of 51-70** – Usually outpatient treatment

**Scores of 30-50** - Partial Hospitalization

**Scores below 35** – Inpatient Hospitalization

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## AXIS 6

- SUICIDE POTENTIAL SCALE
- Thoughts
- Ideations
- Gestures
- Attempts
- Indicators – Diagnosis, history, family

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## Developmental Level – Axis 7 Defense Mechanisms

- Denial
- Projection
- Rationalization
- Minimization
- Splitting
- Sublimation

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