Dsm system

WHY MAKE A PSYCHIATRIC DIAGNOSIS? a) Main function is to provide a succinct means of communicating a large amount of information about a person's illness.

1. Syndrome - cluster of signs and symptoms that commonly occur together.

2. Symptoms - Experienced subjectively; cannot be observed; must be reported by the client.

3. Signs - Experienced both subjectively and objectively, can be observed by others; can be documented objectively.

b) Second function of diagnostic classification is to determine treatment and prognosis. PRIMARY GOALS ATTEMPTED IN THE DSM5 CONSTRUCTION1. Increase clinical utility and validity - to move away from a classification that focused on reliability while inadvertently sacrificing validity toward a classification that is for more clinically useful than DSMIV & far more open to validation.

2. Adopt a more dimensional perspective a) stop thinking of precise, unambiguous, dichotomous, diagnostic categories, b) varied manifestations, c) range of severity (mild, moderate, severe) d) basis for spectrum approach (a symptom exists of a continuum).

3. Eliminate mind-body dualism - all disorders are holistic; they encompass psychological & physiological ex's (environmental, relational, genetic, neurological, endocrinological...)

4. Current research dictates inclusion -disorders on current, sound, scientific research

5. Adopt a developmental perspective - a) like symptoms b) lifespan approach c) cultural formation/cultural formulations interview d) cultural concepts of distress e) Glossary of cultural concepts

6. Emphasize cultural factors - ONDSM SYSTEM SPECIFICALLY FOR YOUFOR ONLY$13. 90/PAGEOrder NowDSM5Is a medical book / it has pick a neurological science approach.

Also very political. Lobbyist in Washington DC campaign for disorders to be in or out of DSM5. Influenced by societal values and beliefs. MAJOR STRUCTURAL CHANGES IN DSM51. Roman Numerals Dropped

2. Multiaxial System Eliminated

3. New Order of Diagnoses

4. Elimination of " NOS" Diagnoses

5. Vast Expansion of V-Codes/Z-Codes

6. Terminology & Coding Etiquette

7. Expansion of Subtypes & SpecifiersMAJOR PROBLEMS WITH THE DSM-IVTR1. Meeting criteria for multiple diagnoses

2. Clusters of disorders that co-occur at high rates

* If someone comes with depression, most likely have anxiety also)

* ADHD also most likely have a learning disorder

3. Symptom bleed in personality disorders

* Some of the same symptoms fir in other disorders also.

4. Widespread use of NOS (Not Otherwise Specified)

*(most common: Pervasive Development Disorder, NOS / Autism, Aspergers - became very much over used.

5. Straddling of diagnosis

Example: Schizo effective disorder - Schizo & depression. CRITERIAa. Rules that describe or define a clinical disorder

b. Criteria specifies the type, intensity, duration, and effect of the various signs, symptoms, and/or behaviors required for a diagnosis. DIAGNOSTIC

UNCERTAINTY

(Role of Clinical Judgment)1. Types of Variance that exists in difficult diagnosis

(a) natural variance,

(b) information variance,

(c) observation & interpretation variance,

(d) criterion variance

2. Obstacles to perfectly reliable diagnoses

(a) Clients who don't quite fit the criteria given

(b) Clients who fulfill the criteria for more than one disorder

(c) Clients who have symptoms of more than one psychiatric disorder (multiple diagnoses)NATURAL VARIANCEDiagnostic Uncertainty - Role of Clinical Judgment

Types of Variance that exists in difficult diagnosis: (a) natural variance, (b) information variance, (c) observation & interpretation variance, (d) criterion variance

Natural Variance - biological markers, type, degree, intensity of psychological symptoms are going to vary from individual to individual

-> fuzzy boundaries

-> best example or prototype

INFORMATION VARIANCEDiagnostic Uncertainty - Role of Clinical Judgment

Types of Variance that exists in difficult diagnosis: (a) natural variance, (b) information variance, (c) observation & interpretation variance, (d) criterion variance

Information Variance - amount and type of clinical information collected from client will vary because the therapist has different sources (talks w/family, spouse, teacher, or parents) of information or client reports two different information.

OBSERVATION & INTERPRETATION VARIANCEDiagnostic Uncertainty - Role of Clinical Judgment

Types of Variance that exists in difficult diagnosis: (a) natural variance, (b) information variance, (c) observation & interpretation variance, (d) criterion variance

Observation & Interpretation Variance - Clinicians are presented with the exact client information BUT both clinicians/therapists interpret the information DIFFERENTLY -> may be due to one clinician attaching/associating the client from their past/history/memory/training

DSM5 helps with this!

CRITERION VARIANCEDiagnostic Uncertainty - Role of Clinical Judgment

Types of Variance that exists in difficult diagnosis: (a) natural variance, (b) information variance, (c) observation & interpretation variance, (d) criterion variance

Criterion Variance - clinicians will use different criteria for diagnosis
- theoretical views of client
- how they attach significant in variance
- * (depending on agency) LCSW vs. LMFT vs. Psychiatrist

MENTAL DISORDER

(DSM5 DEFINITION / p. 20)" A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e. g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. GENERAL CRITERIA IN ALL DIAGNOSES1. The disorder is NOT due to the direct effect of a substance (intoxication or withdrawal).

2. The disorder is NOT due to the direct effects of a general medical condition

3. The disorder causes impairment in social, academic, occupational or other important areas of functioning." OTHER SPECIFIED DISORDER" Is provided to allow the clinician to communicate the specific reason that the presentation does not meet the criteria for any specific category within a diagnostic class. This is done by recording the name of the category, followed by the specific reason.

Example: Client has significant depressive symptoms last 4 week but falls short of the diagnostic threshold for a major depressive episode => Other specified depressive disorder, depressive episode with insufficient symptoms". UNSPECIFIED DISORDER

(formerly NOS)If the clinician chooses not to specify the reason that the criteria are not met for a specific disorder, then " unspecified depressive disorder.

Used when clinician is not able to further specify & describe the clinical presentation.

PRECEDENCE OF DIAGNOSIS / MULTIPLE DIAGNOSISClients often have symptoms consistent w/more than one diagnostic category. The use of multiple diagnoses is ok.

1) TWO BASIC DIAGNOSTIC PRINCIPLES

a) Parsimony - seek the single most economical & efficient diagnosis that accounts for ALL of the information about the client.

b) Hierarchy - remember CONTINUUM

* the most debilitating diagnosis FIRST

* List first the disorder that will be the primary focus of treatment.

a. psychotic, b. mood, c. anxiety - personality, d. somatic, e. sexual, f. adjustmentSTANDARD ASSESSMENTReplaced the GAF.

Used instead of GAF - WHODAS 2:

Standardized assessment

Clinicians' should continuously assess

-> risk of suicidal & homicidal behavior and use standardized assessment for symptoms severity, diagnostic severity, disability optional

PRINCIPAL (INPATIENT) DIAGNOSIS VS. REASON FOR VISIT (OUTPATIENT)Principle Diagnosis: the condition, after study, which

occasioned the admission to the hospital/session

* main focus of attention in treatment

Reason for visit: Patient / client description stating reason for seeking care (or stated by client's representative) such as parent/guardian, paramedic, etc)

*chief concern responsible why client is seeing you.

(PROVISIONAL)* Will see this quite often. In parenthesis because that is how DM5 is listing it

* When have a provisional there is a strong presumption that all of the criteria for this particular diagnosis will be met eventually but it is not in the current diagnosis.

* There is a time period also. (Example:

Axis I code: Major Depressive Disorder has a time frame of 2 weeks). so if someone comes in after 8 days and they meet all of the criteria for MDD but haven't met time period yet, use the (Provisional). / means that it is too early to tell diagnosis BUT you/clinician are almost sure that it is the diagnosis

* Once they meet the criteria then remove the "(provisional)".

Strong presumption of diagnosis, there is a 90% certainty of a particular diagnosis - meets some but not 100% sure

EXCEPTIONS TO USE MULTIPLE DIAGNOSISa) when symptoms are due exclusively to GMC or substance use

b) when symptoms of a less pervasive disorder are due to or included in criteria set of a more pervasive disorder - only diagnosis the more pervasive disorder

c) when symptoms exist on boundaries of two or more disorders, clinical judgment should be used to determine most appropriate diagnosis. RULE OUT" Rule out" goes to diagnostic certainty or uncertainty

*Use when missing criteria but think that it may be diagnosis.

The level of inclusion is there is a 50% level of certainty, however, the criteria still needs to completely fit in diagnosis.

You don't see all criteria but think that it is the diagnosis but have to " rule it out"

Instinct that you may have certainty, they may have D/O

Example:

Axis I: Code Major Dep. D/O (Rule Out)PROVISIONAL VS. RULE OUT (DIFFERENCE BETWEEN THE TWO)Difference between provisional (level of certainty that I have 80 - 90%) vs. Rule out (50% certain go to " rule out"). As you increase your level of diagnostic certainty " I know this is what is going on".

Dx: 100% certain

Provision: 80% - 90%

Rule Out: 50%

DEFERREDI think I have a guess but don't want to guess

Example:

Axis I: Code _____

Axis II: Code DEFERRED

In Axis II Deferred (most likely seen here)

unsure what diagnosis is - 0 have enough time to figure out what client has

(diagnosis) (usually seen in hospital)

Not insured on this for therapists!

Example: 799. 9 Borderline (Deferred)

IN DSM5 PAY PARTICULAR ATTENTION TO: 1) Subtype, Severity, and Course Specifiers

Designed to increase specificity of diagnosis when you have a subtype they are mutually exclusive, you only use one.

Subtypes - denotes as " specify whether". Only 1 subtype can be used

Specifiers - denoted as " Specify if". Use as many specifiers as apply.

Specifiers are moved towards the spectrum (mild, moderate, severe).

2) Classification List

3) V-Codes

4) Assessment Measures: Cross-Cutting Symptom(s) & WHODAS 2. 0

5) Cultural Formulation

6) Conditions for Further Study

7) Glossary: Technical Terms & Cultural Concepts of DistressDSM5 CHANGES OF AXIAL SYSTEMRemoved Axis.

Axis I, II, and III are now combined

Axis IV & V eliminated.

Instead of GAF ....

Clinicians should continuously assess ... risk of suicidal and homicidal behavior

And use standardized assessments for symptom severity, diagnostic severity and disability {optional}

Crosscutting symptom measures (Section III)

WHODAS 2. 0 (Word Health...)FORMER AXIAL SYSTEM OF DSM-IV-TRAXIS I: CODE # Clinical Disorders (something person has)

AXIS II: CODE # Personality Disorders/Mental Retardation (More long term, innate of person)

AXIS III: CODE # General Medical Conditions

AXIS IV: Psychosocial & Environmental Problems

(Tells us why axis I; example - depression because children removed from home, etc).

AXIS V: Global Assessment of Functioning (scale) - 100 point scale, the lower the score the lower functioning person was. There was not reliability in scores. DSM5 CONTAINS 20 CLINICAL CHAPTERS THAT ARE RESTRUCTURED BASED ON:* Like symptoms and relatedness to one another

* Aligns with ICD (International Classification of Diseases (World Health Organization) - 11's content structure

Comprised of 3 sections: Section 1) DSM 5 basics; Section 2) Diagnostic criteria and codes; and Section 3) emerging measures and modelsV-Codes (Z-Codes) in DSM5 p. 715Vast expansion of V-Codes / Other conditions that may be a focus.

* Use instead of Axis IV

May be coded if: " it is a reason for the current visit"

" Helps to explain the need for a test, procedure, or treatment".

Code if it provides:

" Useful information on circumstances that may affect the patient's care, regardless of their relevance to the current visit."

It does not cover it completely.

V Codes/Z Codes are not paid for by insurance company - does not entitle to treatment. they are occurrences.