



**ADVANCING SOCIAL WORK PRACTICE WITH  
CLIENTS: UNDERSTANDING THE DSM-5**

**CONFERENCE REMARKS**

COLUMBIA SCHOOL OF SOCIAL WORK  
DECEMBER 6, 2013

## Contents

|  |    |
|--|----|
| FORWARD TO CONFERENCE PROCEEDINGS.....                     | 3  |
| THE EVOLUTION OF DSM.....                                  | 6  |
| CRITICAL OVERVIEW OF DSM-5.....                            | 9  |
| MOOD AND ANXIETY DISORDERS.....                            | 12 |
| DSM-5 CHANGES FOR TRAUMA AND TRAUMA-RELATED DISORDERS..... | 16 |
| PSYCHOTIC DISORDERS.....                                   | 19 |
| SUBSTANCE USE DISORDERS.....                               | 21 |
| SECTION III OF THE DSM-5.....                              | 24 |
| V-CODES.....   | 27 |
| OUTLINE OF PREPARED REMARKS.....                           | 30 |
| REMARKS ON THE DSM-5.....                                  | 32 |
| DYSPHORIA IN THE DSM-5.....                                | 34 |

## FORWARD TO CONFERENCE PROCEEDINGS

DENISE BURNETTE, PROFESSOR  
MARY SORMANTI, PROFESSOR  
COLUMBIA SCHOOL OF SOCIAL WORK  
DECEMBER 6, 2013

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is the standard classification of mental disorders used by mental health professionals in the United States. It is also translated into more than twenty languages, and diligent attention is paid to ensuring its synchrony with the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems (ICD)*. The DSM thus stands as a near hegemonic reference for assessment and classification of mental disorders in, and increasingly beyond, the United States.

In 2013, almost 20 years after the publication of DSM-IV, the American Psychiatric Association (APA) released the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*. The DSM-5 is designed for use across clinical settings and with community populations by health and mental health professionals with different orientations, and as a requisite tool for collecting and communicating accurate public health statistics. Drawing on the expertise of Columbia University faculty in and beyond the School of Social Work, this conference aimed to provide a scholarly forum for members of the School's community to learn about and discuss substantive changes and critical perspectives of the DSM-5.

Dr. Janet Williams, a distinguished alumna of the School of Social Work and emerita professor of the New York State Psychiatric Institute, opened the conference with an informative review of the evolution of the DSM. Dr. Williams skillfully and creatively oriented participants to the new version of the DSM by historicizing the development of the manual from the nexus of its political, social, and cultural contexts. Building on this background, Dr. Michael First, Professor of Clinical Psychiatry at Columbia and Research Psychiatrist at the Biometrics Department at the New York State Psychiatric Institute, then set the stage for elective workshops on specific diagnostic categories with an engaging and authoritative overview of three central questions concerning the DSM-5: What has changed with the new edition? What has stayed the same? What are the implications for clinical practice?

Characterizing the magnitude of changes from the DSM-IV to the DSM-5 as comparable to those from DSM-III-R to DSM-IV, Dr. First noted the addition of multiple new disorders, elimination of several previous disorders, and combination of others into new disorders. He then described three major changes in the DSM-5: the grouping of disorders based on emerging knowledge of etiological factors (such as shared risk, temperament, or neurocircuitry) rather than descriptive constellations of symptoms; elimination of the multiaxial system of assessment, which was deemed to be at odds with conventional medical diagnostic coding and

reimbursement practices; and replacement of the General Assessment of Functioning (GAF) scale with the WHO Disability Assessment Schedule (WHO-DAS) as one of the dimensional measures in Section III for “Emerging Measures and Models.” Despite the extent of these and other changes, Dr. First concluded that the basic diagnostic approach to mental disorders remains the same in DSM-5 and use of its criteria and terminology is likely to enhance the reliability and effectiveness of one’s clinical practice.

Following the opening presentations by Drs. Williams and First, workshops furthered participants’ exploration of the DSM-5 through focused discussions about changes within specific diagnostic categories. Drawing upon their own practice and research expertise, School of Social Work full-time faculty members Robin Gearing, Lynn Murphy Michalopoulos, and Allen Zweben provided overviews and insights about changes and associated practice implications regarding: 1) Depressive, Bipolar, and Anxiety disorders, 2) Trauma and Trauma-related Disorders, and 3) Substance Abuse Disorders respectively; adjunct faculty members Prudence Fisher, Pascale Jean-Noel, and Lorraine Pirro discussed changes and associated practice implications regarding: 4) Neurodevelopmental and Disruptive Behaviors, 5) Psychotic Disorders, and 6) Cultural Formulation, Personality Disorders, and Other Conditions/Situational Variables that May Affect Diagnosis, Prognosis, or Treatment of an Individual’s Mental Disorder. Although time restrictions precluded detailed reviews of changes in all of the diagnostic categories and features of DSM-5, those that were covered have particular relevance to social workers in a wide variety of practice settings and roles.

Additionally, remarks from Professor Michelle Ballan, and adjunct faculty members, Elijah Nealy and Joan Bell, who comprised the conference’s closing panel, underscored the enormous importance of the social work lens with regards to assessment and intervention in the broad area of mental health. Through their critical examination of ways in which the DSM-5 considers fundamental issues of identity, ability, health, and pathology, they led conference participants in a lively dialogue about the publication’s potential utility and impact. We left the conference reassured that social workers must and will use the DSM-5 thoughtfully, critically, and always in alignment with our core professional values of service, social justice, dignity and worth of the person, centrality of relationships, integrity and competence.

## **References and Resources**

American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (5<sup>th</sup> ed.) Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association (2013). Highlights of Changes from DSM-IV-TR to DSM-5 <http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf>

Kawa, S. & Giordano, J. (2012). A brief historicity of the Diagnostic and Statistical Manual of Mental Disorders: Issues and implications for the future of psychiatric canon and practice. *Philosophy, Ethics, and Humanities in Medicine*, 7 (2) doi: 10.1186/1747-5341-7-2. <http://www.peh-med.com/content/7/1/2>

## THE EVOLUTION OF DSM

JANET B.W. WILLIAMS PHD, PROFESSOR EMERITA OF CLINICAL PSYCHIATRIC SOCIAL WORK  
COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

The first Diagnostic and Statistical Manual (posthumously named DSM-I) was, of course, primarily a nomenclature, rather than the comprehensive manual that we have today. It grew out of a need for a uniform naming system for the disorders for which the field of psychiatry was responsible. Prior to its development, each large teaching center had its own naming system, resulting in a confusing array of locally-grown nomenclatures. This lack of standardization interfered with communication within the field as well as with the collection of medical statistics. In late 1927 the New York Academy of Medicine spearheaded the development of a nationally-accepted standard nomenclature of psychiatric "diseases." This later combined with a statistical manual that the American Psychiatric Association (APA) had developed for use in hospitals, and a classification used by the Army and VA during WWII, and eventually became the DSM, first published in 1952. The publication of DSM-II in 1968 coincided with the appearance of the 8th revision of the International Classification of Diseases (ICD-8), and thereafter, the DSM revisions generally coincided with revisions of the ICD.

Both DSM-I and DSM-II were small, spiral-bound booklets, each about 130 pages. They listed a classification of the mental disorders that were recognized at the time, and most of the disorders had a brief description of their prominent symptoms. Neither of these manuals was of much use to practitioners or researchers because of the brevity and lack of specificity of the descriptions; however, they did provide a system for gathering national statistics. From here on out, the history of the development of the DSMs is guided by a number of prominent researcher/clinicians whose shared goal was to make the DSM useful to practitioners as well as researchers and administrators.

In the early 1970s, psychiatric research was dominated by academic psychiatrists at Washington University in St. Louis, Columbia University, and the NIMH. The group in St. Louis developed the first broad set of diagnostic criteria, which eventually set the stage for DSM-III (Feighner et al, 1972). In 1973, while psychiatry struggled to find a positive identity in the face of anti-psychiatrists like Thomas Szasz, Robert Spitzer lobbied for and was appointed by the APA as chair of a task force to develop the third revision of DSM, DSM-III. In 1975, I joined as Text Editor. From the beginning, DSM-III was guided by a set of clear principles. It would be inclusive, covering all mental disorders, and useful to all mental health practitioners, researchers, and administrators. DSM-III would take a descriptive approach to the definitions of mental disorders, rather than an etiologic one. Previous manuals had embraced psychoanalytic concepts, which were dominant at the time. However, it was recognized that

mental health clinicians could not agree on what caused the disorders, although they could generally agree on what the psychopathology looked like.

There would be specified diagnostic criteria for each mental disorder that would hopefully increase the agreement with which these disorders could be identified. In addition to diagnostic criteria, each disorder would have an expanded text description. In DSM-III this included information in categories such as age at onset, prevalence, and differential diagnosis. A multiaxial system was introduced for the first time, with five axes addressing different types of information including type of disorder, aspects of the environment, and areas of functioning that might be overlooked if the focus were on assessing a single presenting problem. Lastly, compatibility with the codes and terms in the ICD would be maintained. DSM-III was intended to provide a tool for clear communication across mental health professions; to facilitate identification and, ultimately, treatment and prevention of mental disorders; to aid researchers in furthering our understanding of etiology; to help educators teach psychopathology; and finally, to collect accurate national statistics. To assess progress toward this goal, a series of extensive field trials was conducted, and drafts of the manual were revised in line with the results.

There were many hiccups along the way. For example, charges were levied that the Task Force, handpicked by Dr. Spitzer, was not representative of treatment orientations in the field; in response Spitzer added a card-carrying psychoanalyst to the group. The definition of mental disorder became a hot topic (and still is). The psychoanalytic community was furious at the proposed elimination of “Neuroses” from DSM-III. In the end a compromise solution listed in the classification “Dysthymia (Neurotic depression).” Many of these controversies, and the controversial nature of the man who was the head of it, were described in an article in the New Yorker (“The Dictionary of Disorder”) by Alix Spiegel, herself the granddaughter of a former president of the APA.

DSM-III was the first American classification system to include a multiaxial system. This system was an important addition for social workers, as it acknowledged the importance of psychosocial stressors and environmental problems. It also sparked the development of a classification within the field of social work, the Person-in-Environment (PIE) System. DSM-III’s publication also led to a small industry of educational materials, including a series of Casebooks, and the SCID, a widely used interview guide for clinicians and researchers.

As soon as DSM-III was in print, it was clear some adjustments were needed. Hence, work began on a revision, DSM-III-R (1987). This revision corrected inconsistencies that had been overlooked in the preparation of DSM-III, and made fairly major revisions in the areas of Substance Use Disorders and Personality Disorders. However, it was only intended to be a “fine tuning” of its predecessor. DSM-IV was started soon after the publication of DSM-III-R in order to facilitate harmonization with ICD-10.

The lessons learned in developing DSM-III led the Task Force on DSM-IV (now headed by Dr. Allen Frances, a professor of psychiatry at Cornell) to begin by conducting extensive literature reviews of many of the diagnostic categories, to analyze what data could be gathered from the research community, and to conduct multicenter field trials of diagnostic practices. The final volume was published in 1994, and was followed in 2000 by a revision of the text (DSM-IV-TR), leaving the diagnostic criteria unchanged.

It has now been almost 20 years since the publication of DSM-IV. Research in psychiatry has been vigorous, and much has been learned. I am delighted to turn the podium over to Dr. Michael First, who played a key role in the development of DSM-IV, and knows the entirety of DSM-5 as thoroughly as anyone on this planet.

## **References**

Feighner JP, Robins E, Guze SB, Woodruff RA, Winokur G, Munoz R (1972) Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry*. 26: 57-63

Karls JM, O'Keefe M: *Person-in-Environment System Manual*, 2<sup>nd</sup> Ed., NASW Press, Washington, DC, 2008



## **CRITICAL OVERVIEW OF DSM-5**

MICHAEL B. FIRST M.D., PROFESSOR OF CLINICAL PSYCHIATRY  
COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

### **What has changed?**

Although there are hundreds of changes distributed throughout the DSM-5, the magnitude of the extent of changes from DSM-IV to DSM-5 is similar to those from DSM-III-R to DSM-IV. A number of new disorders have been added (i.e., Global Developmental Delay, Social Communication Disorder, Disruptive Mood Dysregulation Disorder, Premenstrual Dysphoric Disorder, Hoarding Disorder, Excoriation Disorder, Binge Eating Disorder, Avoidant/Restrictive Food Intake Disorder, REM Sleep Behavior Disorder, Restless Leg Syndrome, Mild Neurocognitive Disorder), a few have been eliminated (e.g., Sexual Aversion Disorder, Shared Psychotic Disorder, Dissociative Fugue), others have been combined to form new disorders (e.g., Female Hypoactive Sexual Desire Disorder and Female Arousal Disorder combined to form Female Sexual Interest Arousal Disorder), and changes have been made to the criteria sets for virtually every disorder (except the personality disorders, kleptomania, and pyromania). The specifics of these changes will be covered in other presentations in this symposium and will not be covered here.

One of the major differences in DSM-5 is how the disorders are grouped together. In DSM-IV, diagnostic groupings were largely based on superficial descriptive symptomatology, with disorders sharing common presenting symptoms included in the same diagnostic grouping. One of the goals of the DSM-5 revision was to move beyond the DSM-IV descriptive approach and take into account our emerging understanding of the etiological factors underlying mental disorders, such as shared risk, temperament, or neurocircuitry, in the grouping of disorders in the DSM-5. For example, in DSM-IV, the Anxiety Disorders grouping included Panic Disorder, the phobias, Generalized Anxiety Disorder, Obsessive-Compulsive Disorder (OCD), and Posttraumatic Stress Disorder (PTSD), reflecting the fact that patients with these disorders typically presented with anxiety. Although we still do not understand enough about etiology and pathophysiology of mental disorders to base their definitions on laboratory findings, we do know enough about the underlying neurocircuitry, familial inheritance, risk factors, comorbidity patterns, and treatment response of OCD and PTSD to move them into their own separate groupings: Obsessive-Compulsive and Related Disorders and Trauma and Stressor-Related Disorders. Consequently, the entire structure of the classification has been reorganized, beginning with the Neurodevelopmental Disorders (which includes disorders that have their onset during the neurodevelopmental period, from birth to approximately age 18, such as Intellectual Disability, Autism Spectrum Disorder, ADHD); Schizophrenia Spectrum and Other Psychotic Disorders (which now includes Schizotypal Personality Disorder—it is on the genetic

spectrum with Schizophrenia); Bipolar Disorders; Depressive Disorders; Anxiety Disorders; Obsessive-Compulsive and Related Disorders (which also includes Hoarding Disorder, Body Dysmorphic Disorder, Trichotillomania, and Excoriation Disorder); Trauma and Stressor-Related Disorders (which includes PTSD, Acute Stress Disorder, Reactive Attachment Disorder, Disinhibited Social Engagement Disorder, with the latter two included here because, by definition, they occur after exposure to a stressor—in this case severely pathogenic care as an infant). Then, Dissociative Disorders, Somatic Symptom Disorders, Feeding and Eating Disorder, Elimination Disorders, Sleep-Wake Disorders, Sexual Dysfunctions, Gender Dysphoria, Disruptive, Impulse Control and Conduct Disorders, Substance Use and Addictive Disorders (which includes Gambling Disorder), Neurocognitive Disorders, Personality Disorders, and Paraphilias.

Another significant change is the elimination of the multi-axial system in DSM-5. The multi-axial system was first introduced into the DSM-III in 1980 in order to improve clinical assessment practices by encouraging clinicians to focus their assessment on issues above and beyond simply the psychiatric diagnosis. Placing personality disorders and developmental disorders on a separate axis (i.e., Axis II) encouraged clinicians to consider the possible presence of these often-overlooked conditions, which were easy to ignore in the context of more florid clinical conditions such as major depression and conduct disorder. Similarly, placing medical conditions and psychosocial and environmental stressors on separate axes served to increase clinical focus on these important aspects of the presentation. The multi-axial system was eliminated in DSM-5 because it was felt that having a multi-axial system of assessment put psychiatry at odds with medical diagnostic coding and it was felt that placing personality disorders on a separate Axis facilitated the reimbursement discrimination of personality disorders by allowing insurance companies to claim that personality disorders were fundamentally different than the other mental disorders in the DSM. Consequently, in DSM-5 all conditions (i.e., mental disorders, personality disorders, and medical conditions) are listed together without differentiation into separate axes. In lieu of listing psychosocial and environmental problems on Axis IV, DSM-5 offers diagnostic codes corresponding to various kinds of psychosocial and environmental problems in the section for “Other Conditions That May be a Focus of Clinical Attention,” such as V60.0 for homelessness and V60.2 for extreme poverty.

In lieu of the GAF, DSM-5 includes the World Health Organization Disability Assessment Schedule (WHO-DAS) as one of the dimensional measures in Section III for “Emerging Measures and Models.” Entities included in this section “require further study [and] are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use.” (DSM-5, page xliv). The WHO-DAS is a 36 item self-report measure that assesses disability in adults 18 years or older in which the patient is asked to rate how much difficulty he or she has had in specific areas of functioning over the past 30 days. Unfortunately, since the WHO-

DAS was developed for general medical use (as opposed to psychiatric use), it contains items of questionable relevance to most psychiatric patients, such as ““In the past 30 days, how much of a problem did you have washing your whole body?” and “In the past 30 days, how much of a problem did you have standing for long periods, such as 30 minutes?” Moreover, according to the instructions included in DSM-5, the clinician is asked to review the individual’s response on each item on the measure, and if the clinician determines that the score on an item should be different based on the clinical interview and other information available, a “corrected score” should be indicated.

### **What has stayed the same?**

Despite the widespread extent of the changes, the fundamental diagnostic approach used in DSM-5—that is, defining disorders in terms of categorical descriptive criteria sets in which the individual either “has” the disorder or does not have the disorder, based on whether the diagnostic criteria are met—remains the same.

### **What is the significance of this revision to clinical practice?**

Technically, mental health clinicians are not required to use the DSM-5 (or even DSM-IV-TR, for that matter) in their practice. The only legal requirement is to use the ICD-9-CM diagnostic codes (and, starting in October 2014, ICD-10-CM codes) when submitting claims or recording diagnoses on hospital charts -- which are available for free on the National Center for Health Statistics website. However, given that DSM-5 represents the cutting edge of what we know about psychiatric disorders, using the DSM-5 criteria and terminology will likely enhance the reliability and effectiveness of one’s clinical practice.

## **MOOD AND ANXIETY DISORDERS**

ROBIN GEARING PhD, ASSOCIATE PROFESSOR  
COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was released in May 2013, replacing the DSM-IV (1994) and the DSM-IV TR (2000), which incorporated some text revision, but did not contain diagnostic changes. In the nearly two decades from the DSM-IV to DSM-5, research has made steady advancements in the areas of behavioral science, biology, genomics, and neuroscience across mental health professions (e.g., psychiatry, psychology, and social work), and with notable progress in etiology, prevention, and new empirically-supported treatments. Revising the DSM is a monumental task; however, not all advancements can or should be incorporated into the next DSM edition. The DSM-5 does contain a number of distinct and nuanced changes in the criteria, categorization, and classification of mental disorders. Awareness of these changes may assist social workers' identification, assessment, and understanding of mental health disorders. Also, professional understanding of the DSM-5 changes may have implications for the direct provision of care treatment to clients, and work with other helping professions. Although the DSM-5's categorical classifications of Depressive and Bipolar disorders and Anxiety disorders have overwhelmingly retained the criteria from the DSM-IV TR, several important changes have been made. The following paragraphs will review these disorders, including what has changed and what has remained the same, and explore some of the significance of these changes.

Mood Disorders as classified in the DSM-IV TR are now separated into two sequential (showing their connectedness), but separate classification chapters (highlighting their differences): "Depressive Disorders" and "Bipolar and Related Disorders." The DSM-5 Depressive disorders include established unipolar mood disorders (e.g., Major Depressive Disorder), new disorders (Disruptive Mood Dysregulation Disorder (DMDD) and Premenstrual Dysphoric Disorder (PMDD)), and some changes in criteria.

Major Depressive Disorder (MDD) has remained largely unchanged and continues to require the same 5 of 9 symptoms (low mood, loss of interest, weight loss/gain, insomnia/hypersomnia, psychomotor agitation/retardation, loss of energy, worthlessness, reduced concentration, thoughts of death) across a period of two weeks or more. However, MDD has three nuanced changes. One, the subjective report of depression is now defined as "feels sad, empty, hopeless"—the hopeless definition is new and reflects more of a cognitive, not affective, construct. The bereavement exclusion for a major depressive episode has been removed, which reflects that depressive symptoms whether caused by grief or other life stressors are similar, but may raise concerns regarding differentiating between normal and pathological grief. Third, new specifiers (with anxious distress and with mixed features) have

been added. The DSM-5 has renamed Dysthymic disorder (DSM-IV TR) as Persistent Depressive Disorder, which more aptly captures this low-level, but chronic-depressive, condition. The criteria remain unchanged.

Disruptive Mood Dysregulation Disorder (DMDD) is a new disorder for youth under the age of 18 years with severe recurrent temper outbursts manifested verbally (rages) or behaviorally (physical aggression) that are grossly out of proportion in intensity or duration to the provocation, that occur across 2 (or more) settings at least 3 times per week (APA, 2013). The inclusion of DMDD in the DSM-5 may limit the number of youth with such symptoms from being diagnosed with juvenile bipolar disorder (APA, 2013b), due to lack of a viable more appropriate diagnosis. Although concerns of improperly diagnosing common temper tantrums in children have arisen, the criteria for DMDD are specific and would not allow for such a diagnosis by a professional adhering to the standards established in the DSM-5. Premenstrual Dysphoric Disorder (PMDD) is another added disorder; however, this is an established condition previously found in the DSM-IV, where it was relegated to the appendix.

Although Bipolar and Related Disorders is now a stand-alone chapter, few substantive changes have been incorporated in the DSM-5. However, the changes that have been made may have important implications. Manic and hypomanic episodes now include a focus on changes in activity and energy, as well as mood. Also, the nature of the episodes is more narrowly defined—specifically, as the episode requires a “noticeable change from usual behavior,” and that much change is “present most of the day, nearly every day” (APA, 2013). In addition, a hypomania episode now includes the stipulation that symptoms need to have lasted “at least 4 consecutive days.” These changes may significantly reduce false-positives bipolar diagnoses for individuals who may be sub-clinical or who do not have the disorder. Like Depressive disorders, Bipolar disorders have also removed the bereavement exclusion for a MDE<sub>7</sub> and added new specifiers (with anxious distress, with mixed features).

Anxiety disorders received minor changes in the DSM-5. Of note, five DSM-IV TR disorders were reassigned in and out of this section. Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder were appropriately moved out of Anxiety Disorders to the newly developed “Trauma and Stressor-related Disorders.” Obsessive-Compulsive Disorder (OCD) was similarly relocated to the new “Obsessive-compulsive and Related Disorders” section (APA, 2013). In addition, with the deletion of the DSM-IV TR section “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence,” both Separation Anxiety Disorder and Selective Mutism were aptly re-classified as Anxiety Disorders. An important change was the separating of Panic Disorder and Agoraphobia into two distinct, stand-alone disorders. A small, but fitting change was renaming Social Phobia, which may have resulted in stigma, to the more descriptive Social Anxiety Disorder.

Two subtle, but important changes for anxiety disorders are evident the criteria. One, individuals with Agoraphobia, Specific phobia, and Social anxiety disorder are no longer

required to recognize their “anxiety as excessive or unreasonable” (APA, 2000); rather, in the DSM-5, their anxiety “must be out of proportion to the actual danger or threat” (APA, 2013). Also, the 6-month duration criterion, previously limited to youth less than 18 years or age, is now extended to all ages. This change may minimize over-diagnosing of Anxiety Disorders.

Social workers represent approximately 65% of mental health professionals in direct practice within the U.S. (Gibelman, 1995); consequently, it is important for them to familiarize themselves with the specific diagnostic criteria and controversies related to DSM-5 (Littrell & Lacasse, 2012). This knowledge can facilitate critical thinking relevant to their practice context, including fostering effective understanding, assessment, support, and treatment provision to individual clients. In addition, such knowledge may not only enable and empower social workers to advocate for their client, but enable social workers to effectively communicate and partner with other mental health professionals.

The significance of these changes in the DSM-5 will emerge in the coming years, but will doubtlessly be influenced by the rigor of professionals appropriately applying the newly established criteria to their diagnoses. For example, the DSM-5 has worked to “update criteria to reflect cross-cultural variations in presentations” (APA, 2013c); however, application of criteria across individual demographic characteristics (e.g., cultures, race, sex, age) remains unknown. Many of the DSM-5 changes in Mood- and Anxiety-based disorders are subtle and designed to tighten the required diagnostic criteria. This requires that professionals do not quickly apply a diagnosis based on a few symptoms, but rather judiciously review the required criteria with each client before a diagnosis is given. However, it is possible that if the diagnostic rigor is lacking or criteria are ignored, minimized, or discounted, then increased numbers of false-positives and over-diagnosis will emerge and potentially erode some of the established utility of the DSM. The DSM is not a perfect, scientific document, but an evolving—albeit at times flawed—one that offers mental health professionals an important and useful tool. According to Joel Paris’ (2013) critique, the “DSM-5 could remain much like Winston Churchill’s comment on democracy; the worst possible diagnostic system—except for any other yet devised” (p. 191). The DSM-5 offers professionals an important diagnostic tool, but the instrument can and needs to be thoughtfully applied, critiqued, and advanced. As social workers we are in a unique position to be informed by and to inform this developing text.

## References

- American Psychiatric Association (2013a). *Cultural Concepts in DSM-5*. American Psychiatric Association, Arlington, VA.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> ed.* American Psychiatric Association, Arlington, VA.
- American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, Text Revision, 4<sup>th</sup> ed.* American Psychiatric Association, Arlington, VA.

- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> ed.* American Psychiatric Association, Arlington, VA.
- American Psychiatric Association (2013b). *Highlights of Changes from DSM-IV-TR to DSM-5.* American Psychiatric Association, Arlington, VA.
- Gibelman, M. (1995). *What social workers do.* Washington DC: NASW Press.
- Gibelman, M., & Schervesh, P.H. (1993). *Who we are: The social work labor force as reflected in the NASW membership.* Washington DC: NASW Press.
- Littrell, J. & Lacasse, J. (2012). Controversies in psychiatry and the DSM-5: The relevance for social work. *Families in Society, 93*(4), 265-270.
- Paris, J. (2013). *The intelligent clinician's guide to the DSM-5.* Oxford; Oxford University Press.

## **DSM-5 CHANGES FOR TRAUMA AND TRAUMA-RELATED DISORDERS**

LYNN MICHALOPOULOS, PhD, ASSISTANT PROFESSOR

COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

### **Introduction**

Based on extensive research in the trauma field, it was determined that Post-Traumatic Stress Disorder (PTSD) no longer fits into a category of an anxiety disorder. In addition, evidence suggests that PTSD is not solely an internalizing or stress-induced fear-based disorder (Friedman, 2013). Thus, the DSM-5 Anxiety and Dissociative Disorders Work Group created a new chapter to encompass trauma and stress-inducing disorders. The disorders of this new chapter include Acute Stress Disorder, Adjustment Disorder, Reactive Attachment Disorder, and Post Traumatic Stress Disorder. All diagnoses in this chapter require that the “onset or worsening of symptoms were preceded by exposure to an adverse event” (Friedman, 2013, p.549).”

### **What Has Changed with Diagnoses Related to Trauma?**

#### **Acute Stress Disorder:**

Criterion A1 (stressor criterion) of Acute Stress Disorder no longer includes unexpected death of a loved one. Witnessing a death of a loved one must involve either an accident or violence. Criterion A2 (subjective reaction to the event) in Acute Stress Disorder has been eliminated, as research has indicated that experiencing intense fear, helplessness, or horror during the traumatic event does not predict development of symptoms. Finally, individuals may endorse 9 out of the 14 symptoms in any category of Acute Stress Disorder to meet the diagnosis (American Psychiatric Association, 2012).

#### **Adjustment Disorders:**

In the DSM-5, Adjustment Disorders are categorized as a heterogeneous stress-response syndrome after exposure to an adverse event (American Psychiatric Association, 2012).

#### **Reactive Attachment Disorder:**

In the DSM-5, the subtypes of reactive attachment disorder have been redefined as two distinct disorders. Reactive attachment disorder presents like an internalizing disorder with diminished positive affect, whereas disinhibited social engagement disorder is similar to an externalizing disorder, like ADHD (American Psychiatric Association, 2012).

#### **Post-Traumatic Stress Disorder:**



In the DSM-5, criterion A1 (stressor criterion) of PTSD no longer includes unexpected death of a loved one. Witnessing a death of a loved one must involve either an accident or violence. Criterion A2 (subjective reaction to the event) in PTSD has been eliminated as research has indicated that experiencing intense fear, helplessness, or horror during the traumatic event does not predict development of symptoms. In addition, according to the DSM-5, an individual must have one avoidance symptom to meet criteria for PTSD. There are now 20 symptoms, as well as a new category/domain: alterations in cognitions and mood. The new items include: reckless or self-destructive behavior, distorted blame of self or others about the trauma, and persistent negative emotional state. All symptoms are tied to a traumatic event in DSM-5, compared to only 7 in DSM-IV. Furthermore, there are two new subtypes of PTSD in the DSM-5. Namely, there is a dissociative subtype (including symptoms of derealization and depersonalization) and a preschool subtype for children 6 years old and younger (emphasizing behavioral and observable symptoms) (American Psychiatric Association, 2012).

### **What Has Remained the Same with Diagnoses Related to Trauma?**

#### **Acute Stress Disorder:**

The 14 symptoms of the DSM-IV have remained the same in the DSM-5 for Acute Stress Disorder (American Psychiatric Association, 2012).

#### **Adjustment Disorders:**

The subtypes of adjustment disorders in DSM-IV have remained the same (i.e., depressed mood, anxious symptoms, or disturbances in conduct) (American Psychiatric Association, 2012).

#### **Reactive Attachment Disorder:**

The description of the subtypes of Reactive Attachment Disorder have remained the same, i.e., emotionally withdrawn/inhibited and indiscriminately social/disinhibited. However, in DSM-5 they are now distinct disorders, i.e., reactive attachment disorder and disinhibited social engagement disorder (American Psychiatric Association, 2012).

#### **Post-Traumatic Stress Disorder:**

The 17 symptoms of PTSD in DSM-IV have remained the same. In addition the thresholds have remained the same, i.e. 1B + 3C + 2D (DSM IV) and 1B +1C + 2D +2E (DSM-5) (American Psychiatric Association, 2012).

### **Significance of Trauma and Trauma-Related Disorders to Clinical Social Work Practice**

Changes in the DSM-5 have significant implications to diagnosis and clinical social work practice. The removal of the stressor criterion related to an unexpected death of a loved one and the requirement of endorsing at least one avoidance symptom are significant factors in reducing the prevalence of PTSD comparing DSM-IV and DSM-5 among a national probability sample in United States. The new items related to a distorted blame of self or others about the traumatic event is critical for clinical practice as it is an aspect for most trauma-based interventions and also predicts functional impairment and severity of symptoms (Dunmore, Clark, & Ehlers, 2001; Moser, Hajcak, Simons, & Foa, 2007). Research has also indicated that individuals that meet the dissociative subtype are more likely to have experienced severe, repeated, and early childhood trauma, as well as increased functional impairment, interference with emotional learning, and suicidality (Friedman, 2013). Diagnosis with this subtype has implications related to clinical practice in terms of assessment and treatment planning to target these aspects. The development of the preschool subtype allows for clinicians to appropriately diagnose PTSD in young children based on developmentally sensitive criteria. Finally, the development of two new, distinct reactive attachment disorders is important as reactive attachment disorder and disinhibited social engagement disorder differ substantially in terms of course and response to treatment (American Psychiatric Association, 2012). Reactive attachment disorder has internalizing features, whereas disinhibited social engagement disorder has externalizing features. As such, clinicians can now use this diagnosis to develop treatment based on these distinguishing features.

## **PSYCHOTIC DISORDERS**

PASCALE JEAN-NOEL, LECTURER IN SOCIAL WORK

COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

### **What are the 2 changes to Schizophrenia in DSM 5?**

Two changes were made to DSM-IV Criterion A for schizophrenia. The first change is the elimination of the special attribution of bizarre delusions and Schneiderian first-rank auditory hallucinations (e.g., two or more voices conversing). In DSM-IV, only one such symptom was needed to meet the diagnostic requirement for Criterion A, instead of two of the other listed symptoms. This special attribution was removed due to the non-specificity of Schneiderian symptoms and the poor reliability in distinguishing bizarre from non-bizarre delusions.

Therefore, in DSM-5, two Criterion A symptoms are required for any diagnosis of schizophrenia. The second change is the addition of a requirement in Criterion A that the individual must have at least one of these three symptoms: delusions, hallucinations, and disorganized speech. At least one of these core “positive symptoms” is necessary for a reliable diagnosis of schizophrenia.

DSM-IV subtypes of schizophrenia (i.e., paranoid, disorganized, catatonic, undifferentiated, and residual types) are eliminated due to their limited diagnostic stability, low reliability, and poor validity. These subtypes also have not been shown to exhibit distinctive patterns of treatment response or longitudinal course. Instead, a dimensional approach to rating severity for the core symptoms of schizophrenia is included in Section III to capture the important heterogeneity in symptom type and severity expressed across individuals with psychotic disorders.

### **What changes have been made around delusional disorder?**

Criterion A for delusional disorder no longer has the requirement that the delusions must be non-bizarre. A specifier for bizarre type delusions provides continuity with DSM-IV. The demarcation of delusional disorder from psychotic variants of obsessive-compulsive disorder and body dysmorphic disorder is explicitly noted with a new exclusion criterion, which states that the symptoms must not be better explained by conditions such as obsessive-compulsive or body dysmorphic disorder with absent insight/delusional beliefs. DSM-5 no longer separates delusional disorder from shared delusional disorder. If criteria are met for delusional disorder, then that diagnosis is made. If the diagnosis cannot be made but shared beliefs are present, then the diagnosis “other specified schizophrenia spectrum and other psychotic disorder” is used.

### **What is the biggest change to diagnosing schizoaffective disorder?**

The primary change to schizoaffective disorder is the requirement that a major mood episode be present for a majority of the disorder's total duration after Criterion A has been met. This change was made on both conceptual and psychometric grounds. It makes schizoaffective disorder a longitudinal instead of a cross-sectional diagnosis—more comparable to schizophrenia, bipolar disorder, and major depressive disorder, which are bridged by this condition. The change was also made to improve the reliability, diagnostic stability, and validity of this disorder, while recognizing that the characterization of patients with both psychotic and mood symptoms, either concurrently or at different points in their illness, has been a clinical challenge.

### **Is Catatonia a specifier or stand-alone diagnosis?**

The same criteria are used to diagnose catatonia whether the context is a psychotic, bipolar, depressive, or other medical disorder, or an unidentified medical condition. In DSM-IV, two out of five symptom clusters were required if the context was a psychotic or mood disorder, whereas only one symptom cluster was needed if the context was a general medical condition. In DSM-5, all contexts require three catatonic symptoms (from a total of 12 characteristic symptoms). In DSM-5, catatonia may be diagnosed as a specifier for depressive, bipolar, and psychotic disorders; as a separate diagnosis in the context of another medical condition; or as another specified diagnosis.

### **What is attenuated psychosis syndrome?**

This syndrome is characterized by psychotic like symptoms that are below a threshold for full psychosis; (symptoms are less severe and more transient, and insight is relatively maintained).

© 2013 American Psychiatric Association

DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to [www.DSM5.org](http://www.DSM5.org).

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention, and research of mental illnesses, including substance use disorders. Visit the APA at [www.psychiatry.org](http://www.psychiatry.org). For more information, please contact Eve Herold at 703-907-8640 or [press@psych.org](mailto:press@psych.org).

Pascale Jean-Noel, LMSW  
[jeannoe@nyspi.columbia.edu](mailto:jeannoe@nyspi.columbia.edu)  
pj2218@columbia.edu

## SUBSTANCE USE DISORDERS

ALLEN ZWEBEN PHD, SENIOR ASSOCIATE DEAN OF ACADEMIC  
AFFAIRS AND RESEARCH AND PROFESSOR  
COLUMBIA SCHOOL OF SOCIAL WORK  
DECEMBER 6, 2013

### **What has changed?**

The DSM-IV criteria for abuse and dependence are now combined into one disorder—substance use disorders. Table 1 below provides an overview of the 11 criteria encompassing the DSM-5. As indicated in Table 1, seven criteria in the DSM-5 are from the DSM-IV dependence criteria; three abuse criteria in DSM-IV migrated to DSM-5; craving criterion is added while legal problems are removed, making it a total of 11 criteria in DSM-V. The threshold for a substance use disorder in DSM-5 is set at two or more criteria in contrast to the threshold of one or more criteria for substance abuse and three or more criteria in DSM-IV.

**Table 1:**

| IMPAIRED CONTROL  | SOCIAL IMPAIRMENT   | RISKY USE   | PHARMACOLOGICAL CRITERIA   |
|---|---|---|--|
| 1. Taking the substance in larger amounts or over a longer periods than was originally intended*                            | 5. Recurrent substance use resulting in failure to fulfill major role obligations at work, school or home**                                 | 8. Recurrent substance use in situations in which it is physically hazardous**  | 10. Markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed* |
| 2. Persistent desire of unsuccessful efforts to cut down or control substance use*  | 6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by substance use** | 9. Continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem caused or exacerbated by substance use* | 11. Withdrawal as manifested by criteria established for different drug classes (Drug taken to avoid or relieve withdrawal symptoms)*    |
| 3. Great deal of time is spent in activities necessary to obtaining and using the substance or recovering from its effects* | 7. Important social, occupational, or recreational activities given up or reduced because of substance use*                                 |   |  |
| 4. Craving, or a strong desire or urge to use substance***  |   |   |  |

\*Stayed the same  
\*\*DSM-IV substance abuse  
\*\*\* New criterion

Moreover, gambling disorder is now added to DSM-5 with the diagnostic threshold set at four or more criteria. Other new categories include (1) cannabis withdrawal disorder diagnosed as having three or more the following symptoms within one week after cessation of use: irritability, anger/aggression, sleep difficulties, and decreased appetite along and (2) caffeine withdrawal disorder as indicated by having three or more of the following symptoms 24 hours after cessation or reduction of use: headache, fatigue, drowsiness, dysphoric mood, or irritability.

Specifiers are descriptive features of the disorder used to facilitate treatment planning and/or manage the care of patients. Specifiers include level of severity, course of the disorder (remission), subtypes, and the particular circumstances and conditions associated with SUD. They include level of severity indicated as follows: (1) mild (2-3 criteria), (2) moderate (4-6 criteria) and (3) severe (6 or more criteria). Remission is defined as: (1) early remission  $\geq 3$  months but less than  $<12$  months (except craving) and (2) sustained remission ( $\geq 12$  months) without meeting criteria for DSM-5 (except craving). Two new specifiers are added: (1) whether the person has been residing in a controlled environment (substance-free jail, therapeutic communities, and locked hospital unit while in remission) and/or (2) whether the person is receiving maintenance therapy (buprenorphine for opioids, naltrexone for alcohol, and varenicline for smoking) while in remission. The DSM-IV subtype manifesting tolerance or withdrawal was omitted in DSM-5.

For purposes of clarity, the term “substance induced mental disorders” has been changed to substance/medication induced mental disorder. The DSM-IV did not have a category for tobacco abuse, so the criteria for DSM-5 are the same as DSM-IV.

Finally, the omission of the terms “dependence,” “abuse,” or “addicted” is an attempt to destigmatize patients with SUD seen in medical settings and a move toward further medicalization of the disorders.

### ***What has stayed the same?***

Except for the addition of craving and the removal of legal problems, substance use disorder criteria in DSM-5 are the same as in DSM-IV. As indicated earlier, the three abuse criteria in DSM-IV are incorporated into the DSM-5 diagnostic criteria. For more information, see Table 1 above.

### ***What is the significance of this revision to clinical practice?***

The term substance use disorder is more neutral than the term “addiction” or “drug abusers” and may be more acceptable to persons with SUD but not seeking help for these problems. Such individuals may be more ready to seek and accept help if they are not labeled as “drug abusers” or as having “addiction” problems. This may help to facilitate referral process for individuals having SUD seen in medical settings, where such problems are initially detected.

Including gambling disorder in SUD will expand coverage for this disorder, which in turn, may help facilitate early detection, referral, and treatment for individuals diagnosed as having this disorder. Tobacco use disorder is now on a par with other substances, which in turn, may confirm the need to address both biological and behavioral aspects of the disorder.

DSM-V provides a more accurate depiction of various subgroups with SUD. It provides a better understanding of the heterogeneity of the patient population. Having knowledge of patient diversity may help the field move away from a dichotomous view of the problem (e.g., “alcoholic” or not) and may raise awareness that patients have different individual and social coping resources and may need a variety of approaches (i.e., behavioral and pharmacological interventions) to address substance use problems. Having knowledge of patient diversity and the need to offer a menu of options may help the treatment field move away from a “one size fits all” approach.

## SECTION III OF THE DSM-5

LORRAINE M. PIRRO, ADJUNCT LECTURER  
COLUMBIA SCHOOL OF SOCIAL WORK  
DECEMBER 6, 2013

### ***DSM-5, Section III, On The Cultural Formulation Interview.***

If the sixteen-question semi-structured interview is utilized, as I believe the spirit of it intends, the interviewer is an equal partner with the interviewee. The listener's disposition is one that characterizes that of all great practitioners, regardless of their modality, their locale, or the identity of their client partners. This disposition is infused with respect and humility. The cultural formulation interview, in this writer's opinion, is not an interview, but "a way of being" with a therapy partner. Most especially for social work colleagues, it represents a process of engaging. Regardless of whether one is in the classroom, the board room, the emergency room, stateside, abroad, deployed in military conflict, on a street with those who take refuge there, at a bedside, "joining" with a group of trauma victims, allying with troubled adolescents, travelling with the frail elderly, offering comfort to a child separated from all of familiar life—in short, wherever one finds oneself in the service of others, this tool is a gift (that your client will give to you). Expect the unexpected! One learns not merely about symptoms or categorical indices, but about the narrative of felt experience.

If we are willing to nurture our curiosity, we may learn about the texture of distress, as well as the reservoir of resilience. We may be privy to what is unique and special about the person before us, and after absorbing this gifted knowledge, inspiration will likely emerge when we least expect it (and need it most), as the lynchpin to advocate for our partner, to say and do what is needed in the moment, and, ultimately, to nurture agency and positive self-regard. To listen to the context of distress, to attempt to understand precisely how our client perceives vulnerability, in light of his or her cultural identity, is a treasure that unfolds.

Finally, the essence of what is meant by the CFI is embodied in the following quote, words that comprise the wisdom of partners who have taught me so well: "*When I am heard, when I am seen, when I am held emotionally safe, when I have no shame or fear to reveal who I am, I can begin to heal.*"

I encourage you to explore the cultural formulation interview and its supplementary modules which can be found at <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Cultural>.

### ***DSM-5, Section III, On the Alternative Personality Disorder Model.***

*What has changed?*



This is a combination or hybrid approach, meaning that there are six personality disorders, or vulnerabilities, for which a person meets criteria that are categorized by specific impairments (in self or interpersonal functioning) and by the presence of one or more pathological personality traits. It also is a dimensional model. It allows a clinician to individualize each of the six disorders, according to the client presentation. The therapist does this by indicating the level of personality functioning that most closely characterizes a client's functioning (using the DSM-5 Level of Personality Functioning Scale). The model also provides the opportunity to assess up to twenty-five trait facets that are clustered within five overarching trait domains (e.g., negative affectivity versus emotional stability, detachment versus extraversion, antagonism versus agreeableness, disinhibition versus conscientiousness, and psychoticism versus lucidity). The model also introduces the new "Personality Disorder Trait Specified" that allows a clinician to document moderate or greater impairment in personality functioning in two or more of the areas of identity, self-direction, empathy, and the capacity/desire for intimacy. It also allows for the individually tailored assessment of one or more pathological personality trait domains, or specific trait facets, considering all 25 of those traits. Finally, the model allows for the detailed documentation of *healthy* personality functioning for the first time, and for the assessment of personality vulnerabilities that may be the focus of treatment but that do not meet the threshold of moderate or greater impairment.

*What has remained the same?*

The DSM-5 personality disorders in Section II are virtually unchanged from the DSM-IV-TR. The category of "Personality Disorder Not Otherwise Specified" has been replaced by the category of "Personality Disorder Other Specified," available for use in situations in which the clinician chooses to communicate the specific reason that the constellation of symptoms does not meet the criteria for any specific personality disorder, and "Personality Disorder Unspecified," which may be used in situations in which the clinician chooses not to specify the reason that the criteria are not met for a specific personality disorder.

*What is the significance of this revision to clinical social work practice?*

The alternative model of personality disorders is meant as a bridge to the future where it is envisioned that there will be a more dimensional approach that will allow for the "individualization" of personality vulnerabilities, meaning the clinician will be able to create a more precise personality portrait. This would be based on the most central components that comprise healthy functioning (or vulnerability/impairment) as well as the traits (the propensities to behave or act in a particular manner) that are adaptive or maladaptive. It is also designed to address some of the shortcomings of the strictly categorical model, in which a person often meets criteria for more than one personality disorder (overlap) and there is

widespread use (often appropriate, but uninformative) of the unspecified and other specified categories.

***DSM-5 Section III and Online Assessment Measures.***

The American Psychiatric Association is offering a wide variety of emerging measures that can be reproduced without permission by researchers (and by clinicians, for use with their clients), which can be found at <http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Disability>.

These include cross-cutting symptom measures that draw attention to symptoms that are important across diagnoses, available in brief form (Level 1 measures) and more in-depth formats for more detailed follow-up (Level 2 measures). Additionally, there are measures supporting a lifespan approach (for young children, teens, and adults) and a dimensional approach, such as severity measures that correspond to various mental health vulnerabilities—for example, PTSD, depression, and anxiety. Also included are self and proxy administered disability assessments, and brief (e.g., 25 items) and long-form (e.g., 220 items) self-rated and informant versions of empirically-based personality inventories.

## V-CODES

LORRAINE M. PIRRO, ADJUNCT LECTURER  
COLUMBIA SCHOOL OF SOCIAL WORK  
DECEMBER 6, 2013

**Topic:** Other Conditions That May Be a Focus of Clinical Attention or That May Otherwise Affect the Diagnosis, Course, Prognosis, or Treatment of an Individual's Mental Health Vulnerability. (ICD-9-CM: Usually "V" Codes and ICD-10-CM, Usually "Z" Codes)<sup>1</sup>

### *What has changed?*

- A. The DSM-5 expert contributors have identified and centrally located, for ease of use by clinicians, more than 130 client concerns (133 at last count) that might be the focus of attention in a psychotherapy partnership. These are situational variables, *not mental disorders*, which add texture and otherwise fill-in the emotional tapestry of a clinical portrait (i.e., a diagnostic write-up).
- B. The conditions that may be a focus of clinical attention or that may otherwise affect the diagnosis, course, prognosis, or treatment of an individual's mental illness fall into nine broad areas of human experience (and suffering). Moreover, they represent core areas of social work practice.
- C. The categories are: 1) Relational Problems; 2) Abuse and Neglect; 3) Educational and Occupational Problems; 4) Housing and Economic Problems; 5) Other Problems Related to the Social Environment; 6) Problems Related to Crime or Interaction With the Legal System; 7) Other Health Service Encounters for Counseling and Medical Advice; 8) Problems Related to Other Psychosocial, Personal, and Environmental Circumstances; and 9) Other Circumstances of Personal History.<sup>2</sup>
- D. The code and the clinician's note explaining the client problem are placed directly alongside the diagnostic code for the mental disorder. According to the DSM-5, a clinician might highlight the concern if it is a reason for a current visit or helps to explain the need for an evaluation, test, procedure, or treatment.
- E. As you may recall, in the DSM-IV-TR, identified concerns were smaller in number, not centrally located, and indicated on Axis IV, Psychosocial and Environmental Problems. The multi-axial format has been eliminated in the DSM-5.

---

<sup>1</sup> American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013. Web. [Access date: 1 June 2013], [dsm.psychiatryonline.org](http://dsm.psychiatryonline.org).

<sup>2</sup> Ibid.

*What has remained the same?*

Recording psychosocial and environmental problems has always had the intent of systematically documenting critical information that might impact patient care. It remains an essential component of clinical documentation in the DSM-5, and if utilized wisely and vigorously, has the potential of uniquely characterizing clinical social work practice as emblematic of holistic, client-centered engagement.

*What is the significance of this revision to clinical social work practice?*

Recording such information in the client record can underscore critical elements of a treatment plan, or a request for services to an authorizing body. It also, de facto, acknowledges that comorbidity is the rule, not only for many serious mental disorders, but also for what vulnerable clients typically bring to the table—that is, often very material and  *manifold* burdens.

### **Three Illustrative Examples of “Other Conditions...”**

#### **296.44 (F31.2) Bipolar I Disorder, most recent episode manic, severe, with mood congruent psychotic features.**

- **V62.3 (Z55.9) Academic or Educational Problem** Client withdrew from university in his second year as a biochemistry scholar due to impact of initial manic episode associated with bipolar disorder. Re-engaging in his education is the focus of clinical attention due to concomitant anxiety with application process and a fear of humiliation and stigma from “students who saw me ‘lose it’ and who don’t have any problems.” “I’m petrified that they think I’m some weird dude who is going to shoot up the place. I never hurt so much as a flea. Getting sick wasn’t in my plan! I hope I get a second chance.”

#### **296.31 (F33.0) Major Depressive Disorder, mild, with anxious distress.**

- **995.82 (T74.31XD) Spouse or Partner Abuse, Psychological, Confirmed Subsequent encounter.** During the last 7 months, acts of psychological abuse by male partner have included berating and humiliating client; interrogating her as to her activities of daily living and of caring for 10-year-old male child; restricting the victim’s ability to come and go freely; obstructing the victim’s access to assistance (e.g., medical resources: partner refused to provide client with insurance card for three days, to pick up antibiotics, stating client was “not worth the paper the Rx. was printed on”); threatening client with sexual assault if she wasn’t the “useful” partner he deserved; threatening to harm client’s new kitten and to burn her photo album with pictures of family members abroad; unwarranted restriction of client’s access to economic resources (money to buy

groceries and personal hygiene products); isolating the victim from family, friends, and trying to make client think that “she is crazy.”

**331.83 (G31.84) Mild Neurocognitive Disorder Due to Alzheimer’s Disease**

- **V60.3 (Z60.2) Problem related to living alone.** Mr. Katz has no family nearby and few living relatives that are able to care for him should his condition deteriorate. His sister has hired a home attendant for two hours, per day, to prepare nutritious meals and check in on him. She has emergency contact numbers at her disposal.

## **OUTLINE OF PREPARED REMARKS**

MICHELLE BALLAN, ASSISTANT PROFESSOR

COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

The DSM V as opposed to the DSM IV is a compilation of the observations coupled with assessments in a case, used to organize and integrate relevant information around identified core factors pertaining to the individual's challenges. The focus of my remarks will address the category of Neurodevelopmental Disorders, specifically Autism Spectrum Disorder (ASD).

### **Autism Spectrum Disorder**

#### I. Rationale behind change

A major change in DSM-5 is to subsume Asperger's Disorder into the overarching category of ASD. The main reasons for such a direction is that the validity of Asperger's Disorder as a distinct clinical disorder has not been established and that using single category of ASD will facilitate patient care.

#### II. Controversial shift

Sensitivity versus specificity. The argument for subsuming Asperger's Disorder into ASD was partially based on the finding reported by Lord et al. (2012) that the best predictor of which autism spectrum diagnosis a person received was which clinic the individuals went to, rather than any characteristic of the individuals themselves. This finding may reflect to some extent the quality of training and experiences of those diagnosticians, not necessarily an indication of major weakness or problem with the definition and diagnostic criteria of Asperger's Disorder.)

#### III. What does the research tell us?

Heurta et al. (2012) compared to Volkmar et al. (2012). Will we see Asperger's Disorder returning to the DSM VI?

#### IV. Significance of changes for social workers

Social workers require better training to screen and diagnose children at earlier ages; need training in schools of social work and at agencies. Under the DSM-5 criteria, persons with ASD must exhibit symptoms from early childhood, even if those symptoms are not recognized until later. This criteria change encourages earlier diagnosis of ASD; one spectrum but considerable variability along the spectrum. What does this mean for the social worker's skill-set regarding diagnosis (use of diagnostic specifiers) and treatment (uniqueness of different approaches along the spectrum)? The homogenization of a heterogeneous population may mean the

treatments developed will become *less sensitive rather than more sensitive* to important core identifying factors such as language and cognition.

#### V. Significance of changes for social work clients

Perceived threat of loss of service to individuals previously diagnosed with PDD-NOS or Asperger's Disorder.

#### VI. ASD-Relationship to Social Communication Disorder and intellectual Disabilities in the DSM V

## REMARKS ON THE DSM-5

JOAN L. BELL, LECTURER IN SOCIAL WORK  
COLUMBIA SCHOOL OF SOCIAL WORK  
DECEMBER 6, 2013

DSM V, released by the American Psychiatric Association in May of 2013, was the product of more than a decade of research and work by the American Psychiatric Association's DSM V Task Force and Work Groups. It plays a critical role in direct clinical practice with vulnerable persons. It is worth noting that no social workers were included in the membership of the Task Force and Work Groups that authored DSM V, although more than 200,000 mental health clinicians are social workers: we are by far the largest single constituency among all potential users of DSM V (Frances, 2012). While this could lead to arguments about the relevance of DSM V in clinical social work practice, this is shortsighted. DSM V is here. We must shift our attention to the new system's impact on our professional roles and identity as social workers. We must carefully consider the benefits and drawbacks of DSM V, and decide how we can best utilize DSM V to benefit our clients without compromising the core values that define our profession.

Proponents of the DSM claim that the system gives mental health providers a "common language" in which to describe and communicate signs and symptoms of mental health disorders. As critics point out, however, DSM diagnoses create a language of pathology that promotes the "othering" of vulnerable persons. They are thus saddled with a label—another layer of stigma that negatively impacts society's perception and treatment of those who receive mental health diagnoses. Critics of DSM V's applicability to clinical social work practice also point out that DSM V emphasizes measurement of symptoms rather than a more holistic diagnostic system. As the social work profession is becoming more aligned with scientific methodology, some argue that social workers must place more emphasis on quantifiable measures than on collaborative client-centered treatment. This has led many to lament the loss of focus on the "Person in Environment" and the importance of the social work/client alliance, defining principles of the social work approach to mental health care.

The ability to measure the magnitude of mental health symptoms is identified in DSM V as the dimensional approach for quantifying and categorizing psychiatric disorders—dimensions that DSM V authors tout as the greatest advance in the new manual. Put in perspective and applied properly, these three "dimensions" have great potential to benefit clinical social workers.

First, DSM V provides a way to acknowledge symptoms that are not a part of the diagnostic criteria of a patient's primary diagnosis but may be included as a focus of clinical care. This results in a more comprehensive clinical picture and reduces the need to give



multiple diagnoses to communicate a more comprehensive clinical picture. A second “dimension” allows the clinician to measure the severity of a symptom. This allows greater flexibility in assessment within the clinical setting, leading to the exciting possibility of more holistic and nuanced assessment of our clients and more precise use of therapeutic instruments. A third “dimension” provides a way to screen for mental disorders in a general clinical population. This means that more people who are in need of mental health services but have historically been underserved or unidentified might be identified and linked to the services they need.

The social work profession is poised to use our strengths-based training and perspective to apply DSM V for the benefit of our clients. The surgeon’s tools include instruments that can destroy flesh or save lives. The ways in which the surgeon understands these instruments, cares for them, and uses them—not the quality of the instruments alone—determines the surgical outcome. For clinical social workers, DSM V is a more precise instrument. Social workers must apply this new tool with the understanding and care implicit in our core values: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (NASW).

## DYSPHORIA IN THE DSM-5

ELIJAH C. NEALY, LECTURER IN SOCIAL WORK

COLUMBIA SCHOOL OF SOCIAL WORK

DECEMBER 6, 2013

The section of the DSM 4 applying to gender identity disorder was highly contentious during the DSM 5 revision process. In essence, all transgender persons seeking medical transition were forced to be diagnosed with a psychiatric illness. DSM 5 makes numerous improvements toward depathologizing transgender and gender nonconforming persons. One marked improvement in the DSM 5 is that gender dysphoria now forms its own section in the manual as opposed to being part of the section on sexual disorders (as was the case in DSM 4). The title, too, is a marked improvement, letting go of the previous language—“gender identity disorder”—and replacing it with gender dysphoria.

Gender dysphoria is defined in the DSM 5 as “distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender.” It states that not all individuals experience distress as a result of such incongruence, though many are distressed if the desired physical interventions (hormones and/or surgery) are not available. This acknowledgement that not all individuals necessarily experience such distress means not all trans and GNC persons must be diagnosed with Gender Dysphoria. Furthermore, the current DSM focuses on the dysphoria (or distress) as the clinical problem, and not one’s identity *per se*.

In another groundbreaking move, DSM 5 defines gender identity as a category of social identity that refers to a person’s identification as a man, woman, or occasionally, some category other than man or woman. Thus it moves beyond binary classifications and acknowledges that some persons’ gender identities may not fit the stereotypical binary schema. It describes the gender typically assigned at birth and one’s experienced and/or expressed gender, and treats the latter as real and valid phenomena. It goes on to add that the distress is not limited to one’s sense of being the *other* gender, but that it may include a desire to be of an *alternative* gender.

This is good news for transgender and gender nonconforming people and goes a long way toward depathologizing trans and GNC people’s experiences in society. Transgender people are described in the DSM 5 as a “broad spectrum of individuals who transiently or persistently identify with a gender different from their assigned or natal gender.” Again, this definition is broader than earlier DSM version that saw gender identity disorder as applying only to the segment of the population that might be described as transsexual.

DSM 5 speaks to related conditions often associated with gender dysphoria. It reads: “Gender dysphoria, along with atypical gender expression, is associated with high levels of stigmatization, discrimination, and victimization, leading to negative self concept, increased

rates of mental disorder comorbidity, school dropout, and economic marginalization, including unemployment, with attendant social and mental health risks, especially in individuals in resource-poor family backgrounds.” It would be less stigmatizing if this section viewed these dynamics as associated with binary gender constructs and transphobia as opposed to associated with the condition of gender dysphoria.

The major drawback to the new DSM criteria is that it still applies a psychiatric diagnosis to a matter of gender difference or diversity. In the context of health insurance, all transgender and GNC people seeking medical or mental health treatment are still required to have a psychiatric diagnosis for treatment and/or insurance reimbursement.

