

DSM-5: An Overview for Social Workers “Cheat Sheet”

American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. Arlington, VA, American Psychiatric Association, 2013.

Francis, A. *Essentials of Psychiatric Diagnosis: Responding to the Challenge of DSM-5*. New York, New York, Guilford, 2013

Nussbaum, A.M: *The Pocket Guide to the DSM-5 Diagnostic Exam*. Arlington, VA, American Psychiatric Publishing, 2013.

Paris, J. *The Intelligent Clinician’s Guide to the DSM-5*. New York, New York, Oxford University Press, 2013.

www.psychiatry.org/dsm5 DSM-5 online supplemental information. The site serves as a resource for clinicians, researchers, insurers, service recipients and includes information on implementation of the manual, answers frequently asked questions, lists DSM-5 corrections, and provides a mechanism for submitting questions and feedback regarding implementation of the manual. Includes cross-cutting and diagnostic severity measures for relevant disorders, the Cultural Formulation Interview, and other assessment measures.

What Social Workers can be doing now:

- Use the DSM-IV and the ICD-9 codes until September 30, 2014.
- Get the DSM-5 text (and other recommended publications), visit the website (listed above) and begin to familiarize yourself with the material. Download and review the assessment measures and “pilot” the tools in diagnostic evaluations.
- Become familiar with the crosswalk of ICD-9 to the ICD-10 to prepare for implementation of the new codes on October 1, 2014 .
- Take a look at documentation for the most often-used ICD-9 codes in your practice and begin identifying corresponding ICD-10 Codes.
- Pay attention to your online messages from insurance companies (including CMS) regarding adoption of DSM-5 criteria. *For more information about CMS acceptance of DSM-IV and ICD-9-CM codes, visit their online FAQ at:*
<https://questions.cms.gov/faq.php?id=5005&faqId=1817>

Assessment Considerations with DSM-5:

- The relationship comes first. Seek first...and always...to *hear* and *understand* the individual. This takes priority.
- Keep in mind that you are not simply conducting a diagnostic assessment, you are also developing a *case formulation* and are considering your service recipient's "*presentation*" as accurately as possible. The diagnosis and case conceptualization should have *clinical utility*.
- Refer back to the DSM-5 *Definition of a Mental Disorder* and consider the following before formulating a diagnosis: 1). Clinical significance criteria; 2). Assessment of psychological, biological and/or developmental processes underlying mental functioning; 3). Exclusion of dysfunction that is in some way *expected*; 4). Exclusion of dysfunction caused by a disagreement between a person and his/her broader culture; and 5). Clinical usefulness.
- Have a working knowledge of Section II in DSM-5 (including the structure of disorder chapters) so you know where you need to go to winnow down your questions.
- Consider utilization of the Cultural Formulation Interview in ALL assessments (not required, but recommended).

Suggested Order of the Assessment Process:

- Administer cross-cutting assessment measures (levels one and two).
- Conduct clinical interview (informed in part by assessment scores).
- Determine whether or not diagnostic threshold is met.
- Consider subtypes and/or specifiers.
- Consider additional contextual information. Read the disorder text (e.g., course, differential diagnoses), identify level of distress, consider cultural issues, utilize assessor judgment, etc.
- Decide on the most clinically appropriate diagnosis.
- Administer severity assessments (where applicable).
- Apply codes and follow instructions in DSM-5 for coding and recording procedures. In select places, unique codes are given for subtypes, specifiers, and severity.
- Place all mental health and other medical disorders on a single list – with ICD code and name of disorder. Typically, the issue/disorder that you're focusing on as reason for visit/admission is listed first.
- In place of Axis IV, use DSM-5's V/Z/T codes.
- Administer WHODAS 2.0 (suggested, not required). WHODAS provides for a disability rating across a number of functional domains (formerly Axis V), but no replacement for the GAF has been approved as of yet.
- Develop initial service plan and outcome monitoring plan.
- Use assessment measures (severity scales, WHODAS, etc.) to monitor and assess progress at appropriate intervals.

“A Dozen General Tips”

(Adapted from Allen Frances, MD in *Essentials of Psychiatric Diagnosis: Responding to the Challenge of DSM-5*, 2013)

- 1. Hippocrates said that knowing the individual is just as important as knowing the disease.** Don't get so caught up in the details of the symptoms that you miss the context in which they occur.
- 2. Take the time and make the effort.** It takes time to make the right diagnosis – adequate time for each interview, and often multiple interviews over time to see how things are evolving.
- 3. If you hear hoofbeats on Broadway, think horses, not zebras!** When in doubt, go with the odds. Like exotic animals, exotic diagnoses may be fun to think about, but you almost never see them in real life. Stick with the more common diagnoses and you will rarely go wrong.
- 4. Get all the information you can.** No one source is ever complete. Triangulation of data from multiple information sources leads to a more reliable diagnosis.
- 5. Consider previous diagnoses, but don't blindly believe them.** Incorrect diagnoses tend to have a long half-life and unfortunate staying power. Always do your own careful evaluation of the person's entire longitudinal course.
- 6. Constantly revisit the diagnosis.** This is especially true when someone is not benefitting from a treatment that is based on the diagnosis. Clinicians can get tunnel vision once they've fixed on a diagnosis, and may become blinded to contradictory data.
- 7. Children and teenagers are especially hard to diagnose.** They have a short track record, mature at varying rates, may be using drugs or alcohol, and are reactive to family and environmental stresses. This initial diagnosis is likely to be unstable and inappropriate.
- 8. The elderly are also hard to diagnose.** Their psychiatric symptoms may be caused by neurological or other medical illnesses, and they are prone to drug side effects, interactions, and overdoses.
- 9. The less severe the presentation, the more difficult it is to diagnose.** There is no bright line demarcating the very heavily populated boundary between mental disorder and normality. Milder problems often resolve spontaneously with time and without need for diagnosis or treatment.
- 10. When you are in doubt, it is safer and more accurate to underdiagnose.** It's easier to step up to a more severe diagnosis than to step down from it.
- 11. Accurate diagnosis can bring great benefits; inaccurate diagnosis can bring disaster.**
- 12. Always remember the other enduring dictum from Hippocrates: “First, do no harm.”**