Understanding the DSM-IV-TR

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Course Summary

This course will provide mental health professionals with an overview of the DSM-IV-TR. It will give an explanation of the diagnostic classification and the components necessary to make a diagnosis. The multi-axial system will be explained in detail. Advantages and disadvantages of the DSM-IV-TR will be reviewed. The Major Psycho-Diagnostic features of the DSM-IV-TR, Socio Cultural Implications, Groupings of Personality Disorders will also be reviewed. Finally, the mental health professional will learn the key to coming up with an accurate differential diagnosis.

Course Objectives

Upon completing this course students will:

1. Understand the DSM-IV-TR is.

2. How to make a DSM diagnosis.

3. The components necessary in making a diagnosis.

4. Understand the multi-axial system of the DSM.

5. Familiarize themselves with the advantages and disadvantages of the DSM.

6. Learn the Major Psycho-Diagnostic Features of the DSM-IV.

7. Understand the Social-Cultural implication of the DSM.

8. Learn about the Groupings of Personality Disorders.

9. Understand the key to coming up with an accurate differential diagnosis.
Introduction:

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard for classifying mental disorders that are used by mental health professionals in the United States. It is intended to be applicable in a wide variety of contexts and used by clinicians and researchers of many different orientations. (For example; biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems.)

The DSM IV has been designed for use across settings such as inpatient, outpatient, partial hospitalization, consultation-liaison, clinic, private practice and primary care. Professionals that use the DSM diagnosis are psychiatrists, psychologists, social workers, nurses, occupational and rehabilitation therapists, counselors and other health and mental health professionals.

The DSM is also a necessary tool for collecting and communicating accurate public health statistics.


The diagnostic classification is the list of the mental disorders that are officially part of the DSM system. Making a DSM diagnosis consists of selecting those disorders from the classification that best reflects the signs and symptoms that are afflicting the individual being evaluated. Associated with each diagnostic label is a diagnostic code, which is used primarily by institutions and agencies for data collection and billing purposes. These diagnostic codes are derived from the coding system used by all health care professionals in the United States, known as the ICD-9-CM. [http://psyweb.com/mdisord/DSM-IV/jsp/dsm-iv.jsp](http://psyweb.com/mdisord/DSM-IV/jsp/dsm-iv.jsp).
Each disorder included in the DSM includes a set of diagnostic criteria including symptoms that are present and for how long. These criteria called inclusion criteria as well as those symptoms that must not be present called exclusion criteria qualify and individual for a particular diagnosis.

Many users of the DSM find these diagnostic criteria useful because they provide a compact description of each disorder. Use of this diagnostic criterion has been shown to increase diagnostic reliability and increase the likelihood that different individuals will assign the same diagnosis. It is important to remember that these criteria are meant to be used as a guideline by an informed clinician.


The third component of the DSM is the descriptive text that accompanies each disorder. The text of the DSM-IV systematically describes each disorder under the following headings: Diagnostic Features; Subtypes and/or Specifiers; Recording Procedures; Associated Features and Disorders; Specific Culture, Age, and Gender Features; Prevalence; Course; Familial Pattern; and Differential Diagnosis. http://psyweb.commdisord/DSM-IV/jsp/dsm-iv.jsp.

The DSM uses a multi-axial approach to diagnosing because rarely do other factors in a person’s life not impact their mental health. It assesses five dimensions.

**Axis I: Clinical Syndromes**

- This is what is thought of as the diagnosis (e.g. depression, schizophrenia, social phobia)

**Axis II – Developmental and Personality Disorders**

- Developmental disorders including autism, mental retardation and disorders which are typically first evident in childhood.
Personality disorders which are clinical syndromes having more long lasting symptoms and encompass the individual’s way of interacting with the world. They include Paranoid, Antisocial and Borderline Personality Disorders.

Axis III – Physical Conditions which play a role in the development, continuance, or exacerbation of Axis I and II Disorders

- Physical conditions such as brain injury or HIV/AIDS that can result in symptoms of mental illness are included here.

Axis IV – Severity of Psychosocial Stressors

- Events in a person’s life, such as death of a loved one, starting a new job, college, unemployment, and even marriage can impact the disorders listed in Axis I and II. These events are both listed and rated for this axis.

Axis V – Highest Level of Functioning (Global Assessment of Relational Functioning (GARF) Scale

- On the final axis, the clinician rates the person’s level of functioning both at the present time and the highest level within the past year. This helps the clinician understand how the above four axes are affecting the person and what type of changes could be expected.


The GARF Scale can be used to indicate an overall judgment of the functioning of a family or other ongoing relationship on a hypothetical continuum ranging from competent, optimal relational functioning to a disrupted, dysfunctional relationship (APA, 2000).

GARF of 81-100 Overall: The individual is functioning satisfactorily from self-report of participants and from perspective of observers. There is a situationally appropriate, optimistic atmosphere in the family. A wide range of feelings are expressed freely and managed within the family unit. There is a general feeling of warmth, caring, and a sharing of values among all family members. Sexual relations of adult members are satisfactory (APA, 2000).

GARF of 61-80 Overall: Functioning of the individual is somewhat unsatisfactory.
Over a period of time, many but not all difficulties are resolved without complaints. A range of feelings are expressed but instances of emotional blocking or tension is evident. Warm and caring feelings are present but are marred by family members irritability and frustrations. Sexual activity of adult members may be reduced or problematic (APA, 2000).

**GARF of 41-60 Overall:** Relational unit has occasional times of satisfying and competent functioning together, but clearly the relationship is dysfunctional. Unsatisfying relationships tend to predominate. Pain and ineffective anger or emotional complications interfere with family enjoyment. Although there is some warmth and support for members, it is usually unequally distributed. Troublesome sexual difficulties between adults are often present (APA, 2000).

**GARF of 21-40 Overall:** Relational unit is seriously dysfunctional; forms and time periods of satisfactory relating are rare. There are infrequent periods of enjoyment of life together; frequent distancing or open hostility reflects conflicts that remain unresolved and painful. Sexual dysfunction among adults is common (APA, 2000).

**GARF of 1-20 Overall:** Relational unit is too dysfunctional to retain continuity of contact or attachment. Despair and cynicism are pervasive; there is little attention to the emotional needs of others; there is no sense of attachment, commitment, or concern about one another’s welfare (APA, 2000).

**Advantages and Disadvantages of utilizing the DSM IV**

Assigning a diagnosis to a client remains uncomfortable for many counselors. The disadvantages associated with using the DSM have included the promotion of a mechanistic approach to mental disorder assessment. There is a false impression
that the understanding of mental disorders is more advanced than is actually the case. There is an excessive focus on the signs and symptoms of mental disorders to the exclusion of a more in depth understanding of the client’s problems including human development. www.ericdigests.org/1994.htm

Conversely, advantages to implementing the DSM include the development of a common language for discussing diagnoses. There has been an increase in attention to behaviors and the facilitation of the overall learning of psychopathology. Seligman (1990) has indicated that knowledge of diagnosis is important for counselors so that they may provide a diagnosis for clients with insurance coverage and inform clients if their counseling will be covered by medical insurance. In addition, the DSM diagnosis assists with accountability, record keeping, treatment planning, communication with other helping professionals and identification of client with issues beyond areas of expertise. www.eric.digests.org/1994.htm.

Major Psycho-Diagnostic Features of the DSM – IV

According to the DSM-IV, mental disorders are conceptualized as clinically significant behavioral or psychological syndromes or patterns that occur in a “person” and are associated with “distress” (a painful symptom) or “disability” (impairment in one or more important areas of functioning). In addition, the syndrome or pattern must not be an acceptable response to a particular event (APA, 2000).

The DSM system can be difficult to interpret for those with limited clinical expertise or personal familiarity with mental disorders. It is however relatively easy for experienced counselors to learn. Each DSM- IV contains specific diagnostic criteria,
the essential features and clinical information associated with the disorder, as well as differential diagnostic considerations. Information concerning diagnostic and associated features, culture, age, gender characteristics, prevalence, incidence, course and complications of the disorder, familial pattern and differential diagnosis are included. Many diagnoses require symptom severity ratings (mild, moderate, severe) and information about the current state of the problem (e.g. partial, or full remission). [www.eric.digests.org/1994.htm](http://www.eric.digests.org/1994.htm).

The DSM-IV contains fifteen categories of mental disorders:

- Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence – focuses on developmental disorders and other childhood difficulties.

- Delirium Dementia, Amnestic and other Cognitive Disorders – this includes Alzheimer’s conditions and Vascular Dementia.

- Mental Disorders Due to a General Medical Condition – this includes anxiety and mood difficulties as well as personality change due to physical complications.

- Substance Related Disorders – consist of drug and alcohol abuse and dependence.

- Schizophrenia and Other Psychotic Disorders – this is a continuum of difficulties that stress lack of contact with reality as well as Delusional Disorders.

- Mood Disorders and Anxiety Disorders – includes major Depression and Posttraumatic Stress Disorder are featured diagnoses.

- Somatoform Disorders

- Factitious Disorders

- Dissociative Disorders

- Sexual and Gender Identity Disorders

- Eating Disorders
• Sleep Disorders
• Impulse Control Disorders
• Adjustment Disorders
• Personality Disorders

Socio-cultural Implications

Professional counselors utilizing DSM-IV diagnoses yield sizable power that can be interpreted as oppressive to some groups of people. Psycho-diagnosis therefore is reliant on ethno-cultural and linguistic sensitivity (Malgady, Rogler & Constantino, 1987). Clients of lower socioeconomic class may experience, define and manifest mental disorders differently from middle and upper class clients. The DSM’s lack of focus on the problematic features of a social context may be perpetuating the oppression of certain groups of people (e.g., women). www.ericdigests.org/1994.htm

Gender and race of the clinician also have been found to impact an accurate psychodiagnosis (Loring & Powell, 1988). Counselors using the DSM-IV will need to be aware of the implications associated with its use as well as the impact a diagnosis may have on a client’s treatment both within and outside of the counseling process.


Religion is often at odds with the existence of mental disorders. Some religions prohibit or discourage psychotherapy. Some religions prohibit or discourage psychiatric medication. Religious ideation is at times prevalent in psychotic delusions.
Groupings of Personality Disorders

Cluster A – Is characterized by limited range of emotion in social interactions and form few if any close relationships with others. They are generally suspicious others.

**Paranoid:**
- .5% -2.5% of the general population.
- 10% - 30% reside in residential settings.
- 2%-10% participate in outpatient mental health settings.

**Schizoid:**
- This is uncommon in clinical settings

**Schizotypal:**
- 3% of the general population


Cluster B – Characterized by violating the boundaries of others.

**Antisocial:**
- 3% of males and 1% of females in community samples.
- Up to 30% in substance abuse settings.

**Borderline:**
- 2% of the general population
- 10% participate in outpatient programs
- 20% reside in residential settings

**Histrionic:**
- 2%-3% of the general population
- 10%-15% participate in both residential and outpatient settings

**Narcissistic:**
- 1% of the general population
- 2%-16% of the clinical populations


Cluster C – Characterized by being socially inhibited, usually feel inadequate and are overly sensitive to criticism.
Avoidant:
• .5%-1% of the general population
• 10% of the clinical populations

Dependent
• unknown

Obsessive/compulsive
• 1% of the general population
• 3%-10% of the clinical populations


The key to accurate treatment is for the clinician to come up with the accurate differential diagnosis. There are four steps to take that will ensure accuracy.

Step 1:
• Is the presenting symptom real?

There are two conditions in the DSM –IV –TR that are characterized by conscious feigning: One is malingering which is a behavior aimed at the achievement of a clear goal such as insurance compensations, avoiding legal or military responsibilities or obtaining drugs. Behavior that lacks a clear external gain is diagnosed as Factitious Disorder. DSM-IV- TR for Clinicians: Accurate Diagnosis and Effective Treatment Planning (2006).

Step 2:
• Is to Rule Out Substance Etiology

Virtually all psychiatric presentations that are encountered by clinicians can be caused by substances that act on the central nervous system. Failure to recognize substance etiology is a leading cause of diagnostic errors. The presence of substance use and psychopathology does not establish a cause and effect relationship.
Three possible connections must be explored;

1. Does the psychiatric symptoms result from the direct effects of the substance on the central nervous system?

2. Is the substance use a consequence of having a primary psychiatric disorder (e.g. using alcohol or drugs to manage the symptoms)?

3. Are the psychiatric symptoms and the substance using independent?

When diagnosing a substance induced disorder, a clinician must determine whether there is a close relationship between the substance use and psychiatric symptoms. The clinician must also consider the likelihood that the particular pattern of substance use can result in the observed psychiatric symptoms. Finally, it should also be considered whether or not there is a better alternative explanation (i.e., non-substance induced) for the clinical picture. Substance withdrawal must also be considered. The DSM-IV-TR criteria for substance induced suggest that psychiatric symptoms be attributed to the substance use if they remit within a month of the cessation of acute intoxication, withdrawal or medication use. There has been significant debate regarding the four week time limit. DSM-IV-TR for Clinicians: Accurate Diagnosis and Effective Treatment Planning (2006).

**Step 3:**
- Rule out a Disorder due to a General Medical Condition

Any psychiatric presentation can be caused by the direct physiological effects of a general medical condition.
There are five possible relationships to explore;

1. Whether the general medical condition causes the psychiatric symptoms through a direct physiological effect on the brain.
2. Whether the general medical condition causes psychiatric symptoms through a psychological mechanism (e.g., depressive symptoms in response to being diagnosed with cancer – diagnosed as Major Depressive Disorder or Adjustment Disorder.
3. Whether the medication taken for a general medical condition causes the psychiatric symptom.
4. Whether or not the psychiatric symptoms cause or adversely affect the general medical condition;
5. Whether or not the psychiatric symptoms and general medical condition are coincidental.

There are two considerations when ruling out medical conditions;

1. The temporal relationship: Do the psychiatric symptoms begin following the onset of the general medical condition, vary in severity with the severity of the general medical condition and disappear when the general medical conditions resolves?
2. The Atypical Course is the next consideration to look at: If the psychiatric presentation is atypical in symptom pattern, age at onset or course.

**Step 4:**
- Determine the Specific Primary Disorder(s)

A clinician can utilize the decision trees in the DSM-IV along with the diagnostic Criteria Charts. DSM-IV-TR for Clinicians: Accurate Diagnosis and Effective Treatment Planning (2006).

The DSM-IV is not the only psych-diagnostic nomenclature in existence, but it is the most popular. An up-to-date understanding of this diagnostic system and its implications in counseling is imperative for an individual to be effective and ethical in his/her delivery of professional mental health counseling services.
References


http://allpsych.com/disorders/dsm.html