DSM-5

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Objectives DSM-5 Workshop

- Update status of new DSM-5
- Identify categories & changes in DSM-5
- Review response to & critique of DSM-5
- Suggest impact of DSM-5 for Clinical Mental Health Counselors
- Prepare steps to take to be prepared for DSM-5 implementation

Websites on DSM-5

- Official APA DSM-5 site: www.dsm5.org
- DSM-5 on: www.coping.us

Timeline of DSM-5

- 1999-2001 Development of Research Agenda
- 2002-2007 APA/WHO/NIMH DSM-5/ICD-11 Research Planning conferences
- 2006 Appointment of DSM-5 Taskforce
- 2007 Appointment of Workgroups
- 2007-2011 Literature Review and Data Re-analysis
- 2010-2011 1st phase Field Trials ended July 2011
- 2011-2012 2nd phase Field Trials began Fall 2011
- July 2012 Final Draft of DSM-5 for APA review
- May 2013 Publication Date of DSM-5

Revision Guidelines for DSM-5

- Recommendations to be grounded in empirical evidence
- Any changes to the DSM-5 in the future must be made in light of maintaining continuity with previous editions for this reason the DSM-5 is not using Roman numeral V but rather 5 since later editions or revision would be DSM-5.1, DSM-5.2 etc.
- There are no preset limitations on the number of changes that may occur over time with the new DSM-5
- The DSM-5 will continue to exist as a living, evolving document that can be updated and reinterpreted over time

Focus of DSM-5 Changes

- DSM-5 is striving to be more etiological-however disorders are caused by a complex interaction of multiple factors and various etiological factors can present with the same symptom pattern
- The diagnostic groups have been reshuffled
- There is a dimensional component to the categories
- Emphasis was to be on developmental adjustment criteria
- New disorders were considered and older disorders were to be deleted

Deconstruction Movement

- The “deconstruction” movement in schizophrenia (or any of the other categories) seeks to disassemble the existing categorical diagnosis into better-defined working parts, integrating data from genetics, neuroimaging, psychology and other disciplines, and
- then group symptoms that cluster together in order to rebuild them into a more valid working definition of schizophrenia.

Grouping of Diagnostic Categories

The DSM-5 groups are:

1. Neurodevelopmental disorders
2. Schizophrenia and primary psychotic disorders
3. Bipolar and Related Disorders
4. Mood Disorders
5. Anxiety Disorders
6. Disorders Related to Environmental Stress
7. Obsessive Compulsive Spectrum
8. Somatic Symptom Disorder
9. Feeding and Eating Disorder
10. Sleep Disorders
11. Disorders of Sexual Function
12. Antisocial and Disruptive Disorders
13. Substance Abuse-Related Disorders
14. Neurocognitive Disorders
15. Personality Disorders
16. Paraphilias
17. Other Disorders

Obvious Changes in DSM-5 (1)

- The DSM-5 will discontinue the Multiaxial Diagnosis, No more Axis I,II, III, IV & V-which means that Personality Disorders will now appear as diagnostic categories and there will be no more GAF score or listing of psychosocial stressor or contributing medical conditions
- The Multi-axial model will be replaced by Dimensional component to diagnostic categories

Obvious Changes in DSM-5 (2)

- Developmental adjustments will be added to criteria
- The goal has been to have the categories more sensitive to gender and cultural differences
- Diagnostic codes will change from numeric to alphanumeric e.g., Obsessive Compulsive Disorder will change from 300.3 to F42
- They have done away with the NOS labeling and attempted for specificity with the dimensional categorization

Specific Changes Per Diagnostic Category in DSM-5

Neurodevelopmental

- IQ no longer used as criteria for Intellectual Developmental Disorder but the IQ still is understood to be below 70
- Asperger's Syndrome will be lumped into Autism Spectrum since it is at the milder end of the Spectrum

Specific Changes Per Diagnostic Category in DSM-5

Schizophrenia and Other Psychotic Disorders

- Schizotypal Personality Disorder B01 moved to this category
- Added Attenuated Psychosis Syndrome B06

Specific Changes Per Diagnostic Category in DSM-5

Bipolar and related disorders

- Bipolar is now a free standing category
- Taken out of the mood disorder category

Specific Changes Per Diagnostic Category in DSM-5

Depressive Disorders

- Dysthymia now called Chronic Depressive Disorder D03
- Added Prementrual Dysphoric Disorder D04
- Added Mixed Anxiety/Depression D05

Specific Changes Per Diagnostic Category in DSM-5

Anxiety Disorders

- No longer has PTSD in this category
- No longer has OCD in this category
- Social Phobia now called Social Anxiety Disorder E04

Specific Changes Per Diagnostic Category in DSM-5

Obsessive-Compulsive and Related Disorders

- OCD is now a stand alone category
- Body Dysmorphic Disorder listed under OCD as F01
- Added Hoarding under category of OCD as F02
- Trichotillomania now called Hair-Pulling Disorder is listed under OCD as F03
- Skin Picking Disorder moved under OCD as F04

Specific Changes Per Diagnostic Category in DSM-5

Trauma and Stressor Related Disorders

- Trauma related disorders are now a stand alone category
- Reactive Attachment Disorder is now listed here G00
- Added Disinhibited Social Engagement Disorder G01
- Added PSTD in Preschool Children G03
- Acute Stress Disorder is now listed here G04
- PTSD is now listed here G05
- Adjustment Disorders are now listed here G06

Specific Changes Per Diagnostic Category in DSM-5

Dissociative Disorders

- Depersonalization/Derealization Disorder renamed in H00
- Dissociative Fugue has been removed from this category

Specific Changes Per Diagnostic Category in DSM-5

Somatic Symptom Disorder

- Replaced Somatiform Disorders with this category
- Eliminated the following: Somatization Disorder; Pain Disorder; and Hypochondriasis
- Added Complex Somatic Symptom Disorder J00
- Added Simple Somatic Symptom Disorder J01
- Added Illness Anxiety Disorder J02
- Conversion Disorder renamed Functional Neurological Disorder J03

Specific Changes Per Diagnostic Category in DSM-5

Feeding and Eating Disorders

- Pica K00 moved to this category
- Rumination Disorder K01 moved to this category
- Added Avoidant/Restrictive Food Intake Disorder K02
- Added Binge Eating Disorder K05

Specific Changes Per Diagnostic Category in DSM-5

Elimination Disorders

- This category was created as freestanding category
- Enuresis moved to this category L00
- Encopresis moved to this category L01

Specific Changes Per Diagnostic Category in DSM-5

Sleep-Wake Disorders (1)

- Primary Insomnia renamed Insomnia Disorder M00
- Primary Hypersomnia joined with Narcolepsy without Cataplexy M01
- Added Kleine Levin Syndrome M02 (intermittent excessive sleep with behavior change)
- Added Obstructive Sleep Apnea Hypopnea Syndrome M03
- Added Primary Central Sleep Apnea M04

Specific Changes Per Diagnostic Category in DSM-5

Sleep-Wake Disorders (2)

- Added Primary Alveolar Hypoventiation M05
- Added Disorder of Arousal M08
- Added Rapid Eye Movement Behavior Disorder M09
- Added Restless Leg Syndrome M10
- Eliminated: Sleep Terror Disorder & Sleepwalking Disorder

Specific Changes Per Diagnostic Category in DSM-5

Sexual Dysfunction

- Male orgasmic disorder renamed Delay Ejaculation N02
- Premature Ejaculation renamed Early Ejaculation N03
- Dyspareunia and Vaginismus combined into Genito-Pelvic Pain/Penetraion Disorder N06
- Sexual Aversion Disorder combined in other categories

Specific Changes Per Diagnostic Category in DSM-5

Disruptive Impulse Control and Conduct Disorders

- Gambling removed from this category
- Oppositional Defiant Disorder Q00 was moved
- Trichotillomania removed from this category
- Conduct Disorder Q06 was moved
- Antisocial Personality Disorder renamed Dyssocial Personality Disorder Q07 moved to this category

Specific Changes Per Diagnostic Category in DSM-5

Substance Abuse and Addictive Disorders

- Only 3 qualifiers are used in the category: **Use** - replaces both abuse and dependence while **Intoxication** and **Withdrawal** remain the same
- Nicotine Related renamed Tobacco Use Disorder R09
- Added Caffeine Withdrawal R24
- Added Cannabis Withdrawal R25
- Polysubstance Abuse categories discontinued
- Added Gambling R31 added to category

Specific Changes Per Diagnostic Category in DSM-5

Neurocognitive Disorders

- Category replaces Delirium, Dementia, and Amnestic and Other Cognitive Disorders Category
- Now distinguishes between Minor and Major Disorders
- Replace wording of Dementia due to … with Neurocognitive Disorder Associated with for all the conditions listed
- Added Fronto-Temporal Lobar Degeneration S15/S27; Traumatic Brain Injury S16/S28; Lewy Body Disease S17/S29
- Renamed Head Trauma to Traumatic Brain Injury
- Renamed Creutzfeldt-Jakob Disease to Prion Disease

Specific Changes Per Diagnostic Category in DSM-5

Personality Disorders

- Only six Personality Disorders remain in this category: Borderline T00; Obsessive-Compulsive T01; Avoidant T02; Schizotypal T03; Antisocial T04; Narcissistic T05
- Schizotypal Personality Disorder T03 also under Schizophrenia and Other Psychotic Disorders B02
- Antisocial Personality Disorder T04 also under Disruptive Impulse Control and Conduct Disorders as Dyssocial Personality Disorder Q07
- This category no longer stands alone as another AXIS II but rather as a diagnosed category with dimensions

Specific Changes Per Diagnostic Category in DSM-5

Paraphilias

- They all carry over to the DSM-5 new names
- U00 Exhibitionistic Disorder; U01 Fetishistic Disorder; U02 Frotieuristic Disorder; U03 Pedophilic Disorder; U04 Sexual Masochism Disorder; U05 Sexual Sadism Disorder; U06 Tranvestic Disorder; U07 Voyeuristic Disorder

Possible New DSM-5 Disorders

Not added to date:

- Dissociative Trance Disorder
- Anxious Depression
- Complicated /Prolonged Grief
- Factitious disorder imposed on another
- Non-suicidal Self Injury
- Hypersexual Disorder
- Olfactory Reference Syndrome
- Paraphilic Coercive Disorder

Most Discussed Diagnoses
B06 Attenuated Psychosis Syndrome

For Criteria B06 go to:

http://www.coping.us/thedsm5/dsm5specificdiagnoses.html

Critique of B06 Attenuated Psychosis Syndrome

- British Psychological Society (2011) stated the concept of “attenuated psychosis system” appears very worrying; it could be seen as an opportunity to stigmatize eccentric people, and to lower the threshold for achieving a diagnosis of psychosis.
- Society for Humanistic Psychology (2011) stated Attenuated Psychosis Syndrome describes experiences common in general population, which was developed from a “risk” concept with strikingly low predictive validity for conversion to full psychosis.

D00 Disruptive Mood Dysregulation Disorder

For Criteria D00 go to:

http://www.coping.us/thedsm5/dsm5specificdiagnoses.html

Critique of D00 Disruptive Mood Dysregulation Disorder

- Society for Humanistic Psychology (2011) stated Children and adolescents will be particularly susceptible to receiving a diagnosis of Disruptive Mood Dysregulation Disorder or Attenuated Psychosis Syndrome.
- The British Psychological Society (2011) stated putative diagnoses such as Disruptive Mood Dysregulation Disorder presented in DSM-5 are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation. They stated that the criteria used for this diagnosis in the DSM-5 are not value-free, but rather reflect current normative social expectations.

S12 Mild Neurocognitive Disorder

- For Criteria of S12 go to: http://www.coping.us/thedsm5/dsm5specificdiagnoses.html

Critique of S12 Mild Neurocognitive Disorder

Society for Humanistic Psychology (2011) stated that “We are also gravely concerned about the introduction of disorder categories that risk misuse in particularly vulnerable populations. For example, Mild Neurocognitive Disorder might be diagnosed in elderly with expected cognitive decline, especially in memory functions.

Comparison of Diagnoses

- Compare Dysthymic in DSM-IV-TR

To

- Chronic Depressive Disorder in DSM-5

See Comparison of DSM-IV-TR and DSM-5 at: http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=46#

Support for DSM-5 (1)

Kupfer, Regier & Kuhl (2008) reassured the mental health community that the creators of the DSM-5 followed a set of revision principals to guide the efforts of the DSM-V Work Groups: grounding recommendations in empirical evidence; maintaining continuity with previous editions of DSM; removing a priori limitations on the amount of changes DSM-V may incur; and maintaining DSM's status as a living document.

Support for DSM-5 (2)

Middleton (2008) stated that from a clinical viewpoint it is reasonable to hope that the DSM-5 would provide a scheme of diagnostic classification to determine whether or not a particular set of symptoms reflects 'mental illness' (case definition), provides an effective way of improving public health by detecting 'hidden' cases for treatment (case detection), and identifies indications for particular forms of treatment (guide treatment).

Support for DSM-5 (3)

Maser, Norman, Zisook, Everall, Stein, Shettler & Judd (2009) pointed out changes in criterion in DSM-5 will reduce comorbidity, allow symptom weighting, introduce non-criterion symptoms, eliminate NOS categories & provide new directions to biological researchers. They suggested reevaluating threshold concept & use of quality-of-life assessment with framework for such a revision. Drawbacks to changes coming from DSM-5 include retraining of clinicians & administrative & policy changes

Support for DSM-5 (4)

Regier, Kuhl, Kupfer & McNulty (2010) reassured the public in using the following quote “In pursuit of increasing the accuracy and clinical utility of the DSM, we need people with mental illness to help us understand what they are struggling with and how best to identify it.”

Support for DSM-5 (5)

Sinclair (2010) pointed out in the review of the progress made in the revision process that new DSM-5 disorders are considered, based on clinical need, distinct manifestations, potential harm, and potential for treatment.

Support for DSM-5 (6)

British Psychological Association (2011) did support the rating of the severity of different symptoms called “the dimensional classifications, which are proposed in the DSM-5. They supported that use of dimensions because it would take away the focus on specific problems and recognize the variability among symptoms in the diagnosing process. But did criticize as well.

Critique of DSM-5 (1)

Kraemer, Shrout & Rubio-Stipec (2007) : **Disorder** represents something of a medical concern in patient, abnormality, injury, aberration, word is used when etiology or pathological process leading to disorder is unknown.

Disease generally indicates known pathological process.

Disorder may comprise two or more separate diseases, or one disease may actually be viewed as two or more separate disorders, an issue of concern because of well-known comorbidity of psychiatric disorders

Diagnosis procedure to decide whether or not certain disorder or disease is present in patient so a **disorder** or **disease** is characteristic of patient

Diagnosis is opinion that disorder or disease is present. Quality of diagnosis depends on how well opinion relates to characteristics of patient, issue of concern in reliability & validity assessments

Critique of DSM-5 (2)

Dalal & Sivakumar (2009) warned that a classification is as good as its theory. They pointed out that the etiology of psychiatric disorders is still not clearly known, and that we still define them categorically by their clinical syndrome. They stated that there are doubts if they are valid discrete disease entities and if dimensional models are better to study them. They concluded that we have come a long way till ICD-10 and DSM-IV, but there are shortcomings and that with advances in genetics and neurobiology in the future, classification of psychiatric disorders should improve further.

Critique of DSM-5 (3)

Moller (2009) stated that the dimensional perspective recommended to be used in the DSM-5 needs to be pursued cautiously given that using such a perspective would mean that syndromes would have to be assessed in a standardized way for each person seeking help from the psychiatric service system. Therefore this system would need to be multi-dimensional assessment covering all syndromes existing within different psychiatric disorders.

Critique of DSM-5 (4)

McLaren (2010) held that it does not matter if the language in the DSM-5 is updated. It is of no account if categories are reshuffled, broadened, blurred, or loosened; the faults are conceptual, not operational, a case of old wine in new bottles. The DSM-5 Task Force has spent some 3 million hours so far (600 people at 10 hours per week for 10 years), and the biggest jobs are still to come. It has been 3 million wasted hours, just as all those psychoanalytic textbooks and conferences, plus the therapeutic hours on the analyst's couch, were wasted. It is the wrong model.

Critique of DSM-5 (5)

Ben-Zeev, Young & Corrigan (2010) explored the relationship between diagnostic labels and stigma in the context of the DSM-5. They looked at three types of negative outcomes – public stigma, self-stigma, and label avoidance. They concluded that a clinical diagnosis under the DSM-5 may exacerbate these forms of stigma through socio-cognitive processes of groupness, homogeneity, and stability.

Critique of DSM-5 (6)

Andrews, Sunderland & Kemp (2010) concluded that the diagnostic thresholds for social phobia and for obsessive–compulsive disorder are less stringent than that for the other disorders and require revision in DSM-V. The concern is for Bracket Creep.

Critique of DSM-5 (7)

- Wittchen (2010) in her criticism of the process pointed out that the barriers to having women's issues addressed in the DSM-5 is the fragmentation of the field of women's mental health research, lack of emphasis on diagnostic classificatory issues beyond a few selected clinical conditions, and finally, the "current rules of game" used by the current DSM-V Task Forces in the revision process of DSM-5.

Critique of DSM-5 (8a)

The British Psychological Society (2011) put out a major critique of the DSM-5.

Their concern: clients and general public are negatively affected by “medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation.”

Critique of DSM-5 (8b)

The BPS (2011)also stated that putative diagnoses presented in DSM-5 are clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation. They stated that criteria used in DSM-5 are not value-free, but rather reflect current normative social expectations. The BPA pointed out that researchers have pointed out that psychiatric diagnoses are plagued by problems of reliability, validity, prognostic value, and co-morbidity.

Critique of DSM-5 (9a)

The Society for Humanistic Psychology (2011) questioned the proposed changes to the definition(s) of mental disorder that deemphasize sociocultural variation while placing more emphasis on biological theory. They stated that in light of the growing empirical evidence that neurobiology does not fully account for the emergence of mental distress, as well as new longitudinal studies revealing long-term hazards of standard neurobiological (psychotropic) treatment, “we believe that these changes pose substantial risks to patients/clients, practitioners, and the mental health professions in general.”

Critique of DSM-5 (9b)

The Society for Humanistic Psychology (2011) pointed out:

- The proposed removal of Major Depressive Disorder's bereavement exclusion, which currently prevents the pathologization of grief, a normal life process.
- The reduction in the number of criteria necessary for the diagnosis of Attention Deficit Disorder, a diagnosis that is already subject to epidemiological inflation.
- The reduction in symptomatic duration and the number of necessary criteria for the diagnosis of Generalized Anxiety Disorder.

Critique of DSM-5 (10)

ACA Blog (2012) K. Dayle Jones points out: very few substantive changes have been made in response to public comments since first drafts were posted-despite fact so many proposals have been so heavily criticized. Final public comment period originally scheduled for September-October 2011, has been twice postponed because everything is so far behind–first to January-February 2012 and now to May 2012. Given the late date, new public feedback will almost certainly have no impact whatever on DSM-5 & appears to be no more than a public relations gimmick.

Impact of DSM-5 on Mental Health Counselors

Nov 8, 2011 in letter from ACA President Dr. Don W. Locke to APA President Dr. John Oldham, Locke indicated that there are 120,000 licensed professional counselors in U.S. -- second largest group that routinely uses DSM -- and that these professionals have expressed uncertainty about quality & credibility of DSM-5

ACA's Concerns about DSM-5 (1)

ACA is concerned that many of proposed revisions will promote

- Inaccurate diagnoses
- Diagnostic inflation
- Prescribing of unnecessary & potentially harmful medication.

ACA's Concerns about DSM-5 (2)

A major concern for professional counselors is proposed definition of mental disorders. The language suggested implies that all mental disorders have a biological component.

An example of mental disorders that do not necessarily have a biological basis is the severe anxiety an individual may face upon losing a job. This is an environmental issue, according to ACA, not necessarily a problem rooted in biology. The trauma faced by an earthquake victim or the grief following the death of a loved one are other examples of mental conditions that might lead an individual to seek therapy, yet would not qualify under the proposed definition emphasizing a biological basis.

ACA’s Concerns about DSM-5 (3)

"Although advances in neuroscience have greatly enhanced our understanding of psychopathology, the current science does not fully support a biological connection for all mental disorders," Locke stated in the letter.

ACA's Concerns about DSM-5 (4)

The ACA Task force on the DSM-5 took the position that: "in general, counselors are against pathologizing or 'medicalizing' clients with diagnoses as we prefer to view clients from a strength-based approach and avoid the stigma that is often associated with mental health diagnoses."

ACA's Concerns about DSM-5 (5)

ACA had appointed a task force to work on DSM-5 revision in 2010 this task force called for an independent scientific review to ensure that counselors can have faith that the DSM-5 will be a safe & scientifically sound guide to psychiatric diagnosis

ACA’s Concerns about DSM-5 (6)

In a reply dated Nov. 21, 2011 APA addressed ACA's concerns & expressed their strong desire to ensure that the DSM-5 is a tool that is useful to the counseling profession and all mental health providers. The letter also stated that the definition of mental disorder is still a work in progress and, in fact, a revised definition will be posted in the spring and will be open to another round of public comment.

So what should a Clinical Mental Health Counselor do?

1. Keep up with the developments of the new DSM-5
2. Refresh one's skills in doing an effective Initial Assessment Process
3. Keep up with what are the best techniques to get to the "Why Now Issues" facing clients

Steps to formulate an initial tentative diagnosis

1. Do a thorough Psychosocial History
2. Do a Mental Status Examination
3. Develop a Diagnosis using the
    1. Multiaxial diagnosis with DSM-TR-IV
    2. Dimensional diagnosis with DSM-5

In History
First: Establish - WHY NOW?

- You must be able to describe the presenting problem
- Listing specific symptoms and complaints which would justify diagnosis
- You must be able to list the duration of the symptoms or at least estimate the duration

Second: Review client's mental health history

- Previous treatment for mental health problems?
- Hospitalization for psychiatric conditions?
- As child involved in family therapy?
- Treatment for substance abuse problems- outpatient or inpatient?

Third: Determine if client is on any psychotropic medications

- What medications?
- Level of prescription?
- Who prescribed medications?
- For what are the medications prescribed?

Fourth: Review client's relevant medical history

- What is current overall physical health of client?
- When was last physical?
- Is there anything currently or in the past medically accounting for this current mental health complaint?

Fifth: Review client's family history

- Do a genogram of the family
- Identify psychosocial stressors within the family structure
- Mental health and/or substance abuse history with in the family and if successfully treated

Sixth: Review client's social history

- *School history:* Failed grades? Academic success? Social interaction with peers? Highest academic level attained?
- *Community history:* Peer group? Current network of social support? Activities and interests: sports, hobbies, social functioning?

Seventh: Review client's vocational history

- Level of current employment and commitment to current job?
- Relevant past employment history: length of tenure on past jobs, job hopping, relationships with work peers?
- Level of satisfaction with current employment?

Eighth: List client's strengths

- Identify those strengths which make the client a good candidate for successful therapy to address the "here and now" mental health problem
- How motivated for therapy is client?
- How insightful to symptoms?
- How psychologically minded is client?
- How verbal and intelligent?

Ninth: Finally in **History** list liabilities client brings to therapy

- Level of present social support system?
- Mandated for freely coming to therapy?
- Perceptual problems which could interfere e.g. hearing, vision, etc.
- Risk of decompensating (relapsing) if not treated

After Psychosocial History do a **Mental Health Status Exam**

Mental Health Status Exam Rates Client's:

- Appearance
- Consciousness
- Orientation to person, place & time
- Speech
- Affect
- Mood
- Concentration
- Activity level
- Thoughts
- Memory
- Judgment

Once Psychosocial History & Mental Health Status Exam Done!

- Once the Mental Health Status Exam is completed now you are ready to make a tentative
  - Multiaxial Diagnosis using DSM-TR-IV
  - Dimensional Diagnosis using DSM-5

Axis I: Diagnosis or DSM-5 Singular Diagnosis

- You are to use the DSM-TR-IV Number & Description in Axis I or DSM-5 for letter & number
- You first must rule out other diagnoses
- You compare client's symptoms lists with those contained in DSM-TR-IV or DSM-5 to get to most appropriate tentative primary diagnosis

Axis I: Diagnosis (continued)

- You might also list a secondary diagnosis if the client's symptoms match up for this labeling
- You could also list additional diagnoses if the client's presentation allows for these additional diagnoses
- Each must be listed with number & description just like the primary diagnosis

Axis II – Personality Disorder-Mental Retardation

- Use Axis II if client's symptoms match up with a Personality Disorder or Mental Retardation in DSM-IV-TR and list its number & description & if primary put (primary) behind its listing
- Can also list maladaptive behaviors which do not meet DSM-TR-IV criteria here
- Axis II can have: Deferred, or N.A. (not applicable), or left blank

Axis III: Current medical condition affecting mental health

- Lists general medical condition(s) which is (are) relevant to the mental health condition
- The medical condition could affect the treatment of the individual
- Axis III could also be: None or deferred if no current medical condition seems appropriate

Axis IV: Psychosocial & Environmental Problems

- These problems may affect diagnosis, treatment & prognosis
- These problems can initiate or exacerbate mental health problems
- These problems can develop as a result of person's mental health condition

Axis IV: Psychosocial & Environmental - Categories

- Problems with primary support group
- Problems related to social environment
- Educational problems
- Occupational problems
- Housing problems
- Problems with access to health care services
- Problems related to interaction with legal system/crime
- Other psychosocial & environmental problems

Axis V: Global Assessment of Functioning (GAF score)

- GAF score considers psychological, social & occupational functioning on hypothetical continuum of mental health-illness
- Criteria for these scores available p. 34 in DSM-TR-IV
- Methodology of getting to score is given on p. 33 in DSM-TR-IV

It is important to remember

- The Diagnosis given a client is tentative dependent on gathering more data in future anticipated treatment
- Diagnoses can ALWAYS be changed to address changes with the individual's presentation & functioning