DSM-IV: Applications in Clinical Practice

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Workshop Agenda

- DSM Historical Background
- DSM in Practice
  - Establishing Correct Diagnosis - Differential Diagnosis
  - Documenting Medical Necessity (GAF)
  - Goal Setting
Goals of DSM-IV

- **communication**: precision in language, “short-hand”
- **clinical**: facilitate identification, treatment, and prevention of mental disorders
- **research**: further understanding of etiology
- **education**: teach psychopathology
- **data collection**: statistical registry
Early History

- pre-1952: Tower of Babel - 4 national systems in use, multiple state systems
- DSM-I (1952) and DSM-II (1968): glossary definitions of conditions
1980: DSM-III

- descriptive: usable across theoretical orientations
- use of operational criteria in place of glossary definitions
- introduced multiaxial system
- widely accepted by all mental health professionals; translated into over 20 languages
1987: DSM-III-R

- originally intended to be just a “fine tuning”
- corrected inconsistencies and incorporated latest research
- disadvantage: change too disruptive
1994: DSM-IV

- revision process based on empirical review
- elimination of the term “organic”
- expansion of appendix categories
- new and deleted categories
2000: DSM-IV-TR

- Anticipated delay of DSM-V would leave text out-of-date
- Text reviewed for inaccuracies
- Literature review done to update text (e.g., prevalence figures)
- Virtually no changes in criteria sets
DSM-IV in Practice
DSM-IV - “Use of Manual” - I

- Coding and Reporting Procedures
  - subtypes: mutually exclusive and jointly exhaustive
    - e.g., ADHD: Specify type: Predominantly Inattentive Type, Predominantly Hyperactive Type, Combined Type
  - specifiers: not mutually exclusive (optional)
    - e.g., Social Phobia: Specify if: Generalized
Severity and Course Specifiers

- denotes “current” presentation
- currently meets criteria: mild, moderate, severe
  - mild: few criteria over minimum required and no significant impairment
  - moderate: in between
  - severe: many sxs in excess OR sxs particularly severe OR marked impairment
- no longer meets criteria: in partial remission, in full remission, prior history
DSM-IV - “Use of Manual” - III

- recurrence - partial return of sx after period of remission

  - diagnose as “current” prior to full criteria (e.g., current MDE after 10 days instead of 14)
  - if clinically significant: NOS
  - if not clinically significant: no current or provisional dx
comorbidity common

one dx is considered:

- “principal dx” (for inpatients: reason for admission)
- “reason for visit” (for outpatients: condition chiefly responsible for services)

by default: one listed first; if on Axis II, indicate with “principal dx”
DSM-IV - “Use of Manual” - V

- provisional
  - strong presumption that full criteria will be met but not enough information to make firm dx (e.g., patient unable to give adequate hx)
  - in situations where diff dx depends exclusively on duration of illness and total duration in unclear because sxs still present (e.g., Schizophreniform Disorder)
Organization of DSM-IV

- Disorders Usually First Diagnosed in Childhood
- Disorders by Diagnostic Group - historical order: organic, psychotic, neurotic, personality
- Adjustment Disorders
- Other Conditions That May be a Focus of Clinical Attention
DSM-IV in Practice:
I. Establishing Correct Diagnosis: Differential Diagnosis
Comprehensive Differential Diagnosis

- essential to justify treatment plan to case managers
- avoid premature closure
- missing certain diagnoses can be disastrous (i.e., due to general medical condition)
- essential for treatment planning
SIX STEPS IN DIFF DX

- Step 1: r/o substance, medication, toxin exposure
- Step 2: r/o general medical condition
- Step 3: r/o mood disorders
- Step 4: r/o Factitious/malingering
- Step 5: determine amongst similar primary disorders
- Step 6: subthreshold: Adjustment vs. NOS vs. no disorder
STEP 1: R/O SUBSTANCE AS DIRECT CAUSE OF SYMPTOM
STEP 1a: Is substance use present?

- By interview (problem: patients minimize)
- By checking with other informants
- By observation: signs of intoxication, withdrawal, chronic use
- By laboratory measurement: urine tox screen, blood levels, lab findings c/w chronic use
STEP 1b: Causal connection?

Three Possible relationships:

- Substance causing psychopathology (Substance-Induced Disorders)
- Psychopathology causing substance use (Self-Medication)
- Coincidental (true co-morbidity)
Establishing Temporal Relationships

- by history:
  - did one clearly precede the other in time?

- by current observation:
  - during a period of abstinence, what happens to psychiatric symptoms?
STEP 2: R/O General Medical Condition AS DIRECT CAUSE OF SX

- distinguish between GMC as direct physiological cause and GMC as psychological stressor
- different diagnosis and different treatment
STEP 2a: Is GMC present?

- take good medical history
- always ask about medication use, hospitalization, family history of medical illness
- if suspicious (atypical symptom presentation, old age without recent medical evaluation), send patient for directed medical workup
Clues That GMC is causal

- temporal relationship (i.e., Do the psychiatric symptoms begin following the onset of GMC and disappear when the GMC resolves?)

- atypicality in symptoms (severe weight loss with mild depression) or course (onset of mania in elderly patient)
STEP 3: R/O MOOD DISORDER

- mood disorders very common
- may account for many different presentations (somatic, psychotic, sleep symptoms, sexual dysfunction, personality features)
- depressive or manic symptoms may not be chief complaint
STEP 4: ARE SYMPTOMS FOR REAL?

- conscious feigning (Malingering--external motivation, Factitious Disorder--need for sick role)
- unconscious feigning (Conversion, other Somatoform)
Clues to Feigning

- setting (forensic settings, disability hearings, emergency rooms, inpatient hospital)
- atypical symptom cluster (lay person's concept)
- shifting pattern over time
- mimicking role model
- occurrence only under observation
- manipulative or suggestible patient
STEP 5: PICKING SPECIFIC PRIMARY DIAGNOSIS

- must differentiate among disorders usually from same diagnostic class
  - e.g., panic attack as presenting sx: consider Anxiety Disorders

- need to identify key distinguishing points
  (e.g., panic attacks are distinguished by triggering event)

- decision trees helpful
STEP 6: SUBTHRESHOLD PRESENTATIONS

“Subthreshold” is often arbitrary

- three options:
  - Adjustment Disorder - if identifiable causal stressor
  - Not Otherwise Specified - in absence of stressor
  - No Mental Disorder (Other Conditions That May Be a Focus of Clinical Attention, symptoms)
Documenting Medical Necessity

must establish:

- DSM-IV diagnosis
- severity and functional impairment
- concrete impact on person's life, job, relations
- establish definable goals and outcomes
- focused treatment plan with likely efficacy
Using the GAF

- no specific instructions in DSM-IV: flexible adaptation for particular clinical settings:
- current (or lowest) level over past week
  - reflects current or future management needs
  - sets a baseline for improvement
- highest GAF score achieved (typically over past year)
  - reflects individual's potential level of functioning
  - useful as target for termination or maintenance
Symptoms Vs. Functioning - I

- two scales rolled into one: combined in one measure both symptom severity AND level of functioning

  - two components to each 10-point range: symptom severity and functioning
  - within a particular decile if EITHER the symptom severity OR the level of functioning falls within the range

- GAF rating represents the WORST effects of either symptoms or functional impairment
Symptoms Vs. Functioning - II

- FOR EXAMPLE: Refer to Range 41:50:
  - “serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting)” OR
  - “any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)”
Analysis of GAF Scale - I

- 71-100 “normality”: no need for treatment - reassurance

- 41-70 non-psychotic presentations: mild, moderate, “serious” symptoms/functioning
  - mild--depressed mood, insomnia -- occasional truancy
  - moderate -- flat affect, panic attacks -- few friends, conflicts with co-workers
  - serious -- suicidal ideation, severe obsessional rituals, frequent shoplifting -- no friends, unable to keep a job
Analysis of GAF Scale - II

- 21-40 “psychotic symptoms” delusions, hallucinations, disorganized speech/suicidal preoccupation/major impairment in functioning
  - 31-40 impairment in reality testing/disorganized speech - on milder level “sometimes illogical”
  - 21-30 psychotic symptoms that influence behavior/more severe disorganized speech (“incoherent”)
Analysis of GAF Scale - III

- 1-20 dangerousness/inability to take care of self or communicate
  - 11-20 some danger of hurting self/occasional inability to take care of self/inability to communicate
  - 1-10 persistent danger/complete inability to take care of self
GAF by level of functioning

- some in one area 61-70
- moderate in area 51-60
- serious in one area 41-50
- major in several areas 31-40
- all areas 21-30
- occasional inability to maintain personal hygiene 11-20
- persistent inability to maintain personal hygiene 1-10
Four steps to GAF rating - I

- **IMPORTANT NOT TO SHORTCHANGE YOURSELF AND YOUR PATIENT:**

- **STEP 1:** Starting at the highest level, ask yourself “is EITHER the patient’s symptom severity OR the patient’s level of functioning worse than what is indicated in the range?”

- **STEP 2:** Move down until range matches symptom severity OR the level of functioning WHICHEVER IS THE WORST.
Four steps to GAF rating - II

■ STEP 3: Double check: range immediately BELOW should be too severe on BOTH symptom severity AND level of functioning. If not, keep moving down.

■ STEP 4: Determine the specific number within the 10 point range.
  ◆ based on hypothetical comparison with all patients in the range--for example: range 21-30 “behavioral considerably influenced by delusions or hallucinations” -- how excessive the reaction? how often?
Example - Case #1

- A 35 year old advertising executive with Borderline Personality Disorder cuts her wrists deeply with a piece of glass after the married man with whom she spent the weekend informs her that he does not want to see her again. On admission, she states she is sorry she did this and no longer feels acutely suicidal.
Case #1 - continued

- She reports that in general she is very moody and can get very angry and frustrated at the drop of a hat. This results in frequent fights with her co-workers but despite this, she keeps advancing at her agency because of her effectiveness in managing her accounts.
Example - Case #2

- 27 year old man with Schizophrenia, working nights sorting mail at the post office, is seen at a Community MHC for his monthly appointment to manage his antipsychotic meds. He has not had delusions or hallucinations for the past five years but is tangential, has few friends and spends most of his free time watching television. He lives at home with his parents.
Example - Case #3

A 65 year old partner in a large law firm was admitted to the hospital with depressed mood, 30 lb. weight loss, severe EMA, and refusing to go to work because he is convinced his colleagues are trying to poison him. He was treated with a course of ECT with a remission of most symptoms. He is now back home still suffering from insomnia and plans to return to his law firm after another week of recuperation.
Example - Case #4

- A 13 year old boy is expelled from public school after being caught in the act of taking a teacher’s purse out of a locked desk. There had been a series of such thefts over the past month and he has been suspected of being the culprit. He has had behavior problems at school for years, often getting into fights with other children at school and talking back to teachers.
Case #4 - Continued

- He has been suspended several times in the past, once for carrying a concealed switchblade, and several times for smoking marijuana in the school parking lot. He has also done very poorly at school because of his not studying for tests. At home, he is always ignoring the rules, and often stays out with friends until late at night.
Example - Case #5

- A 42 year old accountant who is taking lithium carbonate for a history of Bipolar Disorder comes in to get a blood level drawn and to discuss the possibility of switching to a different medication because of 30 lb. weight gain. He was last hospitalized for a manic episode five years ago.
Case #5 - Continued

- Since that time, he got married, became a partner in his accounting firm, successfully trained for and ran in a marathon, and now reported that his wife is five months pregnant. He reports that he has been getting into more frequent arguments with his wife, but attributes these to increased tensions surrounding the pregnancy.
Symptom-Based Goal Setting

- related to chief complaint and current functioning
- specific and concrete
- realistic and achievable
- set time frame
- determine criteria for reaching goal