

## **Episode 139: The Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders: A conversation**

[00:00:08] Welcome to inSocialWork. The podcast series of the University of Buffalo School of Social Work at [www.inSocialWork.org](http://www.inSocialWork.org). We're glad you could join us today. The purpose of inSocialWork is to engage practitioners and researchers in lifelong learning and promote research to practice and practice to research. We educate. We connect. We care. We're inSocialWork.

[00:00:37] Hello I'm Charles Syms your host for this episode of inSocialWork. The Diagnostic and Statistical Manual of Mental Disorders or as it is often called the DSM is a principle guide utilized in the United States for diagnosing behavioral health disorders. In May of 2013 the fifth edition of the DSM was released its publication was the culmination of more than 10 years of work by the American Psychiatric Association. However the resulting manual has been the subject of concern and controversy over a structure as well as the changes additions and removal of diagnoses and their criteria today even after publication. Questions still remain concerning its use. This podcast features two social work educators both of whom have had significant practice experience. They will explore some of these changes and controversies from the social work perspective in November of 2013 Drs. Robert Keefe and Barber Rittner, members of the University at Buffalo School of Social Work faculty sat down to discuss the new DSM and associate professor Dr. Keefe has been with the faculty at the School of Social Work since 2005. He has previously held faculty positions at Syracuse University and the University of Memphis. Dr. Keefe teaches courses in social work practice and health and mental health care settings. His research focuses on factors that inhibit the provision of an access to health and mental health care by historically oppressed populations. Dr. Rittner is also an associate professor as well as the associate dean for advancement at the School of Social Work. She has been a member of the faculty at the school for more than 17 years. Dr. Rittner has also held faculty positions at the University of Georgia and the University of Nevada Reno. She began her teaching career as an adjunct professor at Barry University in Miami. Her research interests include child welfare children at risk and mental health issues. And now Dr. Robert Keefe and Dr. Barbara Rittner.

[00:03:02] I'm Barbara Rittner with the University at Buffalo School of Social Work. And Rob Keefe and I are going to have a conversation today about the DSM 4TR and the movement into the DSM 5. Rob also is on the School of Social Work at the University at Buffalo. And both of us come from a clinical background so we're going to approach this somewhat as clinicians would thinking about what this transition is about and what the implications are for such practice.

[00:03:33] And I think one of the key questions that has been asked around the country not just locally but broadly is what took so long in getting the new edition of the DSM out for general consumption among clinicians nationwide. And I think that might be a good place just for us to start.

[00:03:52] It's an interesting issue because in 2006 I mean to get a perspective of just how long that they had the first kind of suggestions about what the new DSM 5 is going to look like and they were talking there about what it was going to be. But there's a history of getting these things out later than expected with some exceptions and I don't think most people know that the DSM was really a response to the late 1970s to Medicare coming in and billable services. So what constituted reasonable and customary charges for people with psychiatric illnesses and the American Psychiatric Association couldn't come up with that. Then they couldn't bill for their services for people who were covered under Medicare. So in 1984. And actually a pretty quick run that they put out the the DSM 3. And frankly it was somewhat of a disaster. It was field tested only for usability. It had no reliability or validity. And so they very quickly came up and that's the only time it happened very quickly with the DSM 3 R and that was because the National Institutes of Health

rejected it and said it was unusable and they wouldn't fund any studies. And this is an important consideration. Moving forward it actually took them until 1994 to come up with the first DSM 4 and then about six years later came up with the DSM 4TR and that was about the time they started talking about what the 5 would look like. And there were conceptual issues that I think partly created the lag time the conceptual issues were the DSM up until then had been very and it was around categories of mental illness characteristics of those mental illnesses some presumptions about exclusions of one mental illness for the other. Some are logical you're not both bipolar and a unipolar mood disorder. Those are kind of natural exclusions but they also create some artificial ones like you could not both have major depressive disorder and mental retardation. And people said oh really. That's not what I'm saying in the field. So they wanted to move from this kind of dimensional categorical into a more. I mean this categorical concept into spectrum and mental disorders. And that was a huge shift in terms of the way it was conceptualized. So they had to sell the membership and shift then they had to talk about how it was going to be structured then they had to create the structures and then they started creating the work ropes and at that point it kind of grind to a halt because some of the work groups are very productive and lots of them were not so productive. So part of the lag time was because this was going to represent a dramatic shift in how the DSM was approaching the question of what mental illness and domain the diagnostic domain of psychiatrists which also explains why there's a lot of Wake/sleep disorders and restless leg syndrome and other stuff in the DSM because many psychiatrists in fact they think most of them who are board certified or board certified in both neurology and psychiatry. So it tends to cover stuff that other people consider more medical domain than psychiatric domain. I don't know if that answers the question but that's kind of why it just took so long.

[00:07:28] Well talking about the point you mentioned is with regard to spectrum disorders and I think a lot of our listeners would be very familiar with autism for instance which along with Asperger's is often seen is now seen as a spectrum in the DSM 5. There are other diagnoses that were thought to potentially be along the spectrum particularly the mood disorders with depression and anxiety. And there have been a fair bit of research coming out about that possibility but I never quite understood why that went belly up. Why didn't they take that further. They, meaning the American Psychiatric Association, take it further as a way to include that in the DSM.

[00:08:06] Well actually there was a whole disorder they were going to include in there it was kind of interesting this came out of. Now the head of the National Institutes of Mental Health work a man by the name Dr. Insem and he was one of the people who first observed that when they were using medication for depression and people who also were quote morbid for anxiety both seem to be resolving and the issue was what was the prominent presenting symptom the anxiety spectrum or the depressive spectrum. And in fact in those days before CBT and some of the other sort of more effective ways of treating both of those disorders medication hands down was more effective than traditional psychotherapy. The problem is this when they actually started trying to do research on this and the image supported it was was there really a spectrum disorder of anxiety and depression where the intensity in both paralleled each other rather than the potential for comorbid diagnoses. What became obvious is that you mostly had a comorbid diagnoses that is people who were vulnerable for any polar depression seemed to be more vulnerable for some of the anxiety disorders but not all of the anxiety disorders. And so then you were back to well are you talking about depression and generalized anxiety disorder depression and social phobia and depression and you know what exactly are you talking about here. And so despite an effort to create this continuum it went belly up in a very good turn because there is very little research to support it. It was also by the way the same time where the efficacy of SSRIs with depression and anxiety disorders was also a virtue. And in fact it turns out that SSRIs are no more effective in treating depression than these days the sort of more evidence based treatment protocols using CBT or trauma focus CBT or DMT or any one of a variety of sort of cognitive approaches to treating these disorders

[00:10:26] I think among the controversies here has been which diagnoses are going to be excluded. And we do know that with the access to disorders for instance we are a lot of insurance companies for instance didn't want to pay for the treatment of those disorders. It seemed that for a while the arguments for we should just get rid of them from the DSM. Now I'm not saying that's the reason for removing them from the DSM but we do know that I believe it was 10 of the diagnoses?

[00:10:54] You know people that way and differently and some of them personally because I hated teaching it. I was so relieved to get rid of somataform undifferentiated it because I couldn't figure out what it was

[00:11:12] Well I don't think I've ever had a client with that diagnosis. I may have had one in the 80s like I might have one. But anyway.

[00:11:18] And what's really the difference between somataform and you know your hypochondria which has been renamed they've all been renamed. So the question is did they really eliminate 10 of them or did they rename some of them.

[00:11:32] Yeah.

[00:11:32] And that's also causing some of the confusion because they have renamed a number of them. On the other hand bringing that out there are some things that people expected them to eliminate. They didn't. And people are going but I there were going to eliminate that.

[00:11:47] Right.

[00:11:48] And that was also somewhat controversial in the same way that they eliminated for us as dissociative disorder or fugue. The reality is the research coming out of the Netherlands in particular is highly suggestive that that is a very important sub divisions included the ICD 10 around people who are under high stress becoming dissociative. It's not what we used to think of where it's sort of the movie version where you go off to a new town and become a new person. And you don't remember who you are. It's really around a sort of profound depersonalisation deep realization that occurs with people with trauma histories particularly later onset trauma history meaning over the age of six or so people who come back from war and have a disconnect with their sense of self and then under stress it can become very heightened. And anyone who has another have done so neuro imaging that suggests that that that is a phenomenon that is part of the dissociative component. But it's out. So the elimination is not substantiated by the research. Some of it like somataform undifferentiated is pretty well supported by the research so despite the claims of them that the American Psychiatric Association was going to base this on the research. It's not entirely clear that they were remaining current with research as they did it because the problem with these is the research is always ahead of any publication.

[00:13:24] I think of all the social workers in our community and prior to coming to Buffalo I taught psychopathology for a number of years. And you've certainly taught for a number of years here. I'm wondering what types of things are you hearing from social workers in the community. What are their concerns about the new DSM and the basic question what are we to do as instructors about those concerns that people are having on the community.

[00:13:51] I think probably the biggest ticket item that's out there is this kind of underlying continuous concern that the DSM has two main problems one of which is set the bar so low for what constitutes pathology. That it's not really factoring in normal variances in human behavior and the functionality. And so it really kind of promotes and for social workers this is always concerning the mythologizing of normal behavior. And I think as advocates we need to be supportive of that.

The other one that's probably the one that I found most interesting to follow is that in the 16 dimensions the DSM has they have been to some degree clustered around what would be considered types of medication these diagnoses. It's part of the reason they separated bipolar and major depressive disorders because those are different medication protocols. So there is still a kind of controversial undergirding to this thing about whether or not the pharmaceutical companies contribution to the funding for doing the DSM also compromised the DSM by making it in essence a handbook for the categories of medication. My instinct was to be a little suspicious of initially multiple years ago I was at the International Society for Traumatic Stress Studies when this was in 2012 just before the DSM 5 was being released and then the fall and the head of whose name I'm now drawing a blank. The World Health Organization's organization for the what are known as the F 10 through F. I think it's 40 or something. Ninety nine categories. These are the neurological biological mental illness categories and we started talking about how the DSM 5 and the ICD 10 differ and because it's a medical conference disclaimers have to be made. The minute you approach the podium who you've been supportive of and what he stood up and he said we're with the World Health Organization. I have no conflict of interest. And our research has not been supported by any organization other than the World Health Organization and the United Nations. And there was a thunderous applause. So in a way it suggested that that these concerns that the DSM 5 has somewhat been too focused on category by medication that is medication diagnosis match rather than the research that would say these are how the diagnoses are manifesting. Here's the research to support it. I'm beginning to think might be a concern that social workers should have. That is it in essence promoting the use of psychotropic medication pretty continuously at a pretty low level. And so I think it's a real concern. I also think the reality of today's practice of medicine is that physicians make their income in essence by doing diagnosis and prescribing medications that don't really have time to do a lot of psychotherapy. So it's easy to find fault with them but I think the practice realities for psychiatry has become pretty complicated. That said so people are wondering whether they should adopt. There are two things they ought to think about upfront. First of all is the National Institutes of Mental Health said that at this point they are not using the DSM 5 on grant applications. They are recommending the ICD 9 ICD 10. Now it's got some heavy pushback from the American Psychiatric Association because this is the same thing that happened with the DSM 3 when the National Institutes of Mental Health said it's not good enough for us. American Psychiatric Association had in essence a schematic that was not really usable by most researchers and consequently neither insurance companies or practitioners. So they very quickly within four years got three you're out. The same thing is sort of sitting here right now. But someone backed up and said Well but part of it is well he found it interesting his word. National Institutes of Mental Health are moving now towards trying to figure out what actually causes most mental illness because the reality is with very few of them we don't have a clue what's causing most of the mental illnesses that we have labeled with a variety of labels. We know with the symptom cluster looks like for depression but we don't really know what causes it which is part of the problem with SSRIs. What we do know is that the higher rate of prescribing SS R Is very rapidly drove a very high rate of conversion to bipolar disorder which is we sort of started tracking it in the 1990s by 10 years later when and some of the other folks had been looking at this the correlation between the SSRI prescription rate and the increased rate of bipolar disorder was a very convincing match. So I think in a way some is not entirely wrong to step back and say wait a minute before we keep testing medications maybe the emphasis in the National Institutes of Mental Health ought to be on trying to figure out what causes these manifestations of mental illness what are the biological neuro biological components of this. Now the American Psychological Association went after it because of the research when they went out and tried to field trial. The new DSM and frankly it's not that it's so confusing because of the diagnoses you're used to are still mostly in there. What had changed was the descriptors had changed. We used to have a kind of much clearer sense of you know you need find a set dose of these possible symptoms in depression over a two week period for adults. One way it's fits kid and you need to have some solutions like it's not provoked by medication i.e. cardiac patients taking calcium channel blockers or beta blockers both have a tendency to produce

on the medications symptoms that look like depression. So there were some exclusions that were in there. So now the descriptions are very much broader. And so when people tried to match the case study to the descriptions the capps came out and point to six which are really poor. They really are they are pretty much comparable to blind poking an answer rather than actually trying to use the criteria to diagnose the disorder. The American Psychiatric Association said Well there are no better or worse than they were on the earlier ones which frankly isn't a great reason to accept it. The American Psychological Association said no it's really bad. And so they have rejected it as lacking both reliability and validity. And so my advice to social workers out in the field is kind of to take a wait and see. And I'm hedging my bet and I'm redoing psychopathology and I'm using both the ICD 10 and the DSM 5 because at this point it doesn't seem as if it's going to be warmly embrace the DSM 5. I think it's more likely to be considered. It it really backs the issue why we have to have something different than the rest of the world is using. Yeah and the rest of the world is using the ICD 10. I mean literally everybody but the United States uses the ICD 10. So why do we need a different schematic for mental illness than the one and originally it had better things than the ICD in the access it had the five access which allowed us to thing complexity to thinking about how globally functional somebody was. And they up the access out to the one thing that was distinctive about the DSM is no longer a part of it

[00:22:40] And as a social worker I am very concerned about removing any access in general particularly those that help us to get a clear idea of a client's context of the life the client lives and with the removal of any of the access for just telling us some of the psychosocial issues that our clients face and it just helps contextualize the real life experience of our clients. can you help us to understand why the EPA would decide to remove and access when we have good research that substantiates its use.

[00:23:20] Beats me but I am not really being glib. I think in a way the issue of the ICD 10 is partly what drove they were trying to look in some ways more like the ICD 10 and to align so that people could work theoretically across both manuals. Course that begs the question why would you bother but to work across both manuals and I think they were right you know for those of us who worked with the medical profession in mental health settings and in health settings where psychiatric evaluation was done the truth is very rarely did you ever see anything put down on anything other than Axis 1 and sometimes access to it was personality disorder and the rest of it include. And then there would be this GAF. And I was never really sure how somebody came up with the GAF. Now the Global Assessment of Functioning without considering the biased psychosocial stressors that the person had at the same time as you're looking at the presentation of this mental illness so there's no question that for those of us who approached the social workers the five axes were very helpful in thinking through it sort of like when you know somebody who's had a traumatic brain injury and you don't go to the axis 3 to see where the injury is and what part of their functioning is going to be compromised as a result of that injury and then to think about what the implications are in terms of their activities of daily living their social structure whether or not moving them could cause problems with disorientation and dislocation. You know all of those things were very helpful particularly for caseworkers and social workers in medical settings as you well know to begin to think about what the issues were in terms of both setting up a case plan or setting up a treatment plan. And so for me the loss and for many of us the loss was confusing. But if you look at if this is not really the American's mental health practitioners manual it's the American Psychiatric Associations Diagnostic and Statistical Manual it's intended for a psychiatrist who frankly didn't use it very much so I think the answer is in the audience. But the problem is most people doing diagnoses these days are not psychiatrists. There are a lot more of us than there were of them. So it's advocacy for us is I think more confusing and I think for somebody like you who comes out of the medical suffering then I think you know the issue is actually even more different with the diagnosis on axis 3 where we're looking at the health care issues the medical diagnoses are very important. They help give some idea of the severity perhaps of Axis 1.

[00:26:12] So if we have a substance abuse disorder or an axis 1 is very helpful to know if there's something going on an axis 3 such as problems with the liver or palms and kidneys as a result of substance abuse or skin problems when we're talking about intravenous drug use like dermatitis and cellulitis that helps us in our treatment planning because it gives us an idea of what other services that we need to be mindful of that our clients are going to have to access in the course of their treatment. I think that the ICD is a very important issue for us to be considering in this country. The ICD does not come out as a new addition and it very often doesn't the DSM actually come out more frequently than does the ICD. And I'm wondering if there is some research or some indication that the ICD perhaps is less current or is based on less current research than is the DSM. Is that an argument that American Psychiatric Association may be using to keep putting forward new editions of the DSM when other professional groups are advocating for the ICD.

[00:27:17] You are absolutely right in that sense but the interesting thing about the ICD 10 is that it also can change a whole lot to them. Depression is depression; bipolar is bipolar. They have nine clusters as opposed to 16 clusters. So they're in much bigger categories. And interestingly enough of the ICD is not something you use to figure out what the diagnosis is. It's something you use to confirm what the diagnosis is. It presumes almost that you're in the mental health field. And remember this is something that is also the medical schematic the ICD is not exclusive to psychiatry or to mental health issues. So just above it as I remember or something like infectious diseases. So it really is intended for a practitioner who thinks maybe that somebody has a behavioral syndrome associated with physiological disturbances that include for instance eating and sleeping disorders. And so they might go in there simply to figure out which one of those said it is but it presumes that the person already knows something about that. It's really based around educated and then this is a manual to get you in essence to get make sure you've got the right label. It's much less intended to if you read the DSM it really talks about prevalence levels and other stuff which is not in the ICD or the ICD does not presume to tell us whether we should expect it more in this group or less in that group. I think that's actually one of the shortcomings of the ICD 10 and I think is one of the strengths continues to be the strengths of the DSM 5. Is there some effort not a sufficient effort to look at differential diagnosis in children and the aging population. They promised to do more of that in the original schematic for the DSM 5 than they actually produced in terms of whether or bipolar 10 year old a true bipolar or 10 year old looks different than a 30 year old with bipolar disorder. You know that was one of the things that I really wanted us to talk about the DSM 5 did promise that there would be more age appropriate criteria. And that really was an issue with the earlier DSM in the sense that sometimes the criteria didn't really give firm much based on the age of the person you're evaluating.

[00:29:43] You know they did with major depression say well two weeks of one versus a longer period of time for somebody else who is older in general. Has the AP been successful in the development of the DSM 5 with developing more age appropriate criteria.

[00:29:58] Frustratingly No. And it was interesting at that same conference that I mentioned the ISTSS conference first. Who is now the chair of the DSM 5 version. He replaced that or stood up before this group had. The interesting thing about how we came up with the two week diagnosis is that a bunch of psychologists basically sat around saying well how well you know one month is too long by then the person could be fully suicidal. So in one week isn't really long enough. So we'll hit the mental we'll do two weeks and he said literally that's how some of those time dimensions. So I was surprised when I saw that that hadn't changed at all. As we know there is pretty strong evidence depending on the type of depression that you have that exactly what you said aging populations tend to have a slower and more cumulative trajectory towards a major depressive disorder. So embarrassed watching over a period of time and kids can be profoundly depressed very very quickly. Now he did recognize that they said well we'll use one week for kids because they tend to

do it faster. So I was actually hoping more to see that. Probably the biggest disappointment and that is that in psychiatric disorders there is a lot of literature very important literature now and what early onset schizophrenia and childhood onset schizophrenia looks like and how it differs from what you see in adult onset schizophrenia both in terms of the nature of the symptom presentation but also the intensity of them and there is almost no age differentiation. And at the time they were putting this together and there was a substantial body of literature and it was mostly international literature for this substantial body of literature on this stuff. So that's one of those promises we really wish that they had done a better job. They were also talking about cultural difference right. They still have culturally based diagnoses which they had in the DSM 4TR or things that are unique to various cultures. But within the diagnosis they didn't do much of that and frankly that becomes unwieldy because then you're including these groups but not that group. And at what point do you stop including titration issue you you've got to have enough people that practitioners are going to bump into this representative and the group and so I mean I think that was an ambitious sort of concept but I think once the reality of trying to get it together frankly that's what the literature is for. But you're seeing that client and this client is from a culture that you're not familiar with. Go do some research and figure out how this plays out if you're dealing with somebody who's Hmong. And this is the first time you've seen somebody who is from that group. And I think that we sometimes forget the DSM and the ICD are not in essence give the reference to the bible of how you do that. So it is really just basically a place for you to kind of organize your thoughts. But anybody who's not current in the literature doing this kind of practice is not practicing responsibly because what's in the DSM and what's in the literature often very significantly. And so I think we as faculty have an obligation to say you know stay current in literature don't presume that the DSM is going to be current in the literature because the last time it took 13 years for the new version to come out in 13 years is a lot of change in literature. One thing I'd like to focus on just a little bit is the issues around both acute stress disorder and post-traumatic stress disorder. We're seeing any number of people coming back from war torn countries or seeing people move to this country from war torn countries. And I think that issue of post-traumatic stress disorder brings together some of the issues and concerns we have around culture and how to approach our work with people from different cultures who have had clear trauma histories. The diagnosis of PTSD at one time was even thought to be perhaps an adjustment disorder because clearly every difficulty adjusting to trauma which was very minimizing of us to say it that way. But that was an argument once about the diagnosis and then should the diagnosis be considered among the anxiety disorders. So where is the APA now falling with respect to post-traumatic stress disorder.

[00:34:32] It was probably the bloodiest fight of all I imagine some of them were really intense. A number of organizations the dissociative disorders organization ISTSS and trauma disorder organization and a number of people in the V.A. and other practice environments with high rates of trauma did not think that it was appropriate for PTSD acute stress disorder to be clustered under anxiety. And there were good reasons for it not to be but the American Psychiatric Association to their credit also didn't want to create lots of little tiny clusters. So the question was does the anxiety that gets produced as a result of trauma constitute a Anxiety Disorder and in fact the anxiety disorder split out to things they split out the obsessive compulsive disorders and they split out the trauma and acute stress disorders. The interesting element about that was then what to do with adjustment disorders. And I think your point is well taken about well you know what is this continuum really from just one disorder to acute stress disorder PTSD ironically enough which I find fascinating. One of the few areas where there's actually some fairly good understanding about what causes the symptoms whether there are cultural differences or not. And this really is amazingly about cortisol levels and they first started publishing before Israeli soldiers. Both men and women because they're women and men on the front line much longer than ours have had cortisol swabs done before they at the point of induction into the army. And then depending on the amount of trauma they've done compare the amount of cortisol in a soldier system when they came back and then looked at those again symptoms. Now what they found was that cortisol in fact is a

pretty good predictor of people who are going to have various levels of PTSD. We kind of understand what's causing it. And also it's lingering impact long after the trauma is quote behind you. Although it's not follow this route. So the question was Is this also true that people with adjustment disorder because up until then PTSD had really been described predominantly as direct as opposed to vicarious traumatization. So if you survived because you were on leave when your unit got wiped out theoretically you wouldn't have PTSD because you weren't in an imminent risk of dying situation. Oh yeah you could tell that to the person with PTSD symptom we're now able as a result of exactly what in some is talking about now that we understand a little bit more about the biology of PTSD. It is different than what you see in generalized anxiety disorder or social phobia or specific phobias. It really is quite different. So when we started looking at adjustment disorders and I always think about this every one of us listening to this has some friends who went through a divorce a number of years ago. And really it was an awful traumatic divorce and it still controls their life in the same way that very often people who have had these traumatic experiences or motor vehicle accidents can measure life before and after the trauma and when they started looking at the neurobiology of these severe traumatic non-life threatening events they found much the same thing that we're seeing with acute stress disorder and PTSD. So in this case the breaking of those together make complete and total sense. And it's also consistent with the ICD 10 which is recognize that for a long time. So you know in this case the DSM was way behind the ICD 10 which saw PTSD and stress disorders as a separate category.

[00:38:44] Now as we're about to conclude I think one of the things that might be helpful for our listeners would be for us to talk some about how we should move forward because there are problems with the DSM 5 there were problems as we mentioned that we knew about with the DSM 3 which is why the DSM 3R but we do have the DSM 5. It is out there with all of these controversies that's out there how should we now move forward with respect to the DSM 5. Is it something we should become clinically conversant in. Do you think that we're going to perhaps stick with the DSM 4TR until the ICD grabs agree to hold in this country. How should we move forward.

[00:39:28] These are difficult times because in no sense you're going to have to be concerned first and as a practitioner with all of them I know you're going to be getting case files that have ICD 10 diagnoses you're going to have them when DSM 5. But of course their history is going to be quote DSM 4. I don't mean to be a social worker here. But so what. Yeah I mean the reality is that I think we have two responsibilities one of which is to understand the role of social work and clinical social work and community based social work is to try to create the best possible outcomes for clients. That means being able to talk to the insurance companies that they're using the DSM 5 is a DSM 5. If they are stayed with the DSM 4 and are moving to ICD 10 then you better know how to use the ICD 10. My experiences clients very rarely unless they're very intellectual care with their diagnosis says that's not you know in a way if we were a main client focus then what we really need to do is what we should be doing all along which is not chase a diagnosis that is not try to figure out based on their behavior. What questions asked to confirm in diagnosis what we really want to do is to remember that our responsibility is to understand what's happening with the client. Understand that within the context of the clients environment and stress service that they're experiencing within their environments and the obstacles that they have to becoming maximally efficient and functional within their environments. What does a client want. I teach a case where a client wanted to be put on a medication that was going to cause tardive dyskinesia. And he won the right in the courts to be put on that medication because to him it was worth it for the sleep. Now we have to continuously keep in mind what the advocacy roles are of social workers for their clients and for their organizations within their communities. I also think the issue is social work needs to contribute to the research. The access for may be gone but the issues and access for have not gone anywhere. And so I think we have an obligation to make sure that when we're working in teams in which there is a research agenda that we think about the larger context and we think about the psychosocial

stressors and we think about the role of social work in terms of mediators in the community sense of that and Brokers services to get the best outcome. So my feeling is these are interesting times in which we live. And so our responsibility is really to be knowledgeable and to be able to move within systems and the system you were born in may use the DSM 5 then learn the DSM 5. The system you're in may move towards the ICD 10 which I think the V.A. interestingly enough it's going to be moving to. So then you better be conversant in the DSM and in the ICD 10. So I think one of the things I've always felt best about our profession is that we know how to adapt and be flexible in that process to say you know or the constituents what are the needs. Who are they interacting with. What's our role. How do we broker across those systems and as long as we continue to think micro mezo macro then we'll know which one we don't know. My feeling is that it's foolish to dig in and say well I'm only using this or that because it's a changing landscape.

[00:43:05] You have been listening to a conversation about the DSM 5 with doctors Robert Keefe and Barbara Rittner. We hope that you found the subject matter of thought provoking. I'm Charles Syms your host. Please join us again at inSocialWork.

[00:43:28] Hi I'm Nancy Smyth Professor and Dean of the University of Buffalo School of Social Work. Thanks for listening to our podcast. We look forward to your continued support of the series. For more information about who we are as a school our history or online and on the ground degree and continuing education programs we invite you to visit our website at [www.SocialWork.buffalo.edu](http://www.SocialWork.buffalo.edu). And while you're there check out our technology and social work research center you'll find that under the Community Resources menu.