# THE WETC PSYCHOLOGY NEWSLETTER

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**"Find the Truth, Tell the Story"**

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## DSM-5: Chicken Little Was Right!

I spent 30 years as a psychology professor teaching classes in research, statistics and clinical psychology. I also spent the last 28 years working as a forensic psychologist, most of which was in workers' compensation. I'm not a particularly open person but given my history and what is probably a rapidly approaching retirement, I think it's time for me to speak out and summarize my overview of the current psych claim system in California.

First, it is my opinion that the vast majority of psychological and psychiatric evaluations written for the workers' compensation courts are flawed and do not constitute substantial evidence. I have written about these problems at various times in my earlier WETC Newsletters, but to make a long story short the essential problem comes down to the consumers being faced with a blind item. In this case the consumers are the attorneys and the courts. Since they are trained in the law and not psychology or psychiatry, they cannot really appreciate the poor overall level of reporting. Simply put, attorneys and judges do not see or understand the substantial flaws found in the vast majority of psychological and psychiatric reports.

Second, the American Psychiatric Association (APA) published a new diagnostic manual last month, which is called the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). As I pointed out in my June, 2013 newsletter, the DSM-5 changed the relationship between the diagnostic criteria for the various mental disorders and the doctor's freedom to use their "clinical judgment" to override the diagnostic criteria. In the past, the DSM-IV-TR allowed that override to occur if the patient fell "just short" of meeting the criteria. In the DSM-5, the diagnostic criteria are "offered as guidelines" that can be overridden by the doctor's "clinical judgment," which comes down to their subjective impressions. Of course, the cynic in me believes that this means that in the current adversarial and competitive workers' compensation system this will come down to the doctor essentially stating, "Ms. Jones has a Major Depressive Disorder because I say she has a Major Depressive Disorder." How sad!

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Third, the DSM-5 eliminated the Global Assessment of Functioning (GAF) scale. From my point of view, as I noted in my WETC Newsletter of December, 2011 this was no great loss since the GAF scale has no less than three major problems that from a scientific measurement point of view makes it grossly subjective. However, although the APA would have us believe the DSM-5 is now the law of the land it appears likely that Labor Code section 4660 will require the use of the outdated or obsolete GAF found in the DSM-IV-TR for assessing permanent psychiatric disability.

The only possibly worse outcome than continuing to use the GAF scale is to use what appears in the DSM-5, the "WHODAS 2.0," which reminds me of the comical phrase "whodat?" from the old minstrel shows of the 19th century. Considering what I'm about to tell you about the WHODAS 2.0, a reference to the 19th century is totally appropriate. The WHODAS 2.0 is the World Health Organization Disability Assessment Schedule 2.0. The name sure

sounds impressive, but for those of you who have not had an opportunity to look at pages 747 and 748 or the DSM-5, the WHODAS 2.0 is not only laughable but tells you as much about the true nature of the DSM-5 as perhaps any other part of that manual.

The WHODAS 2.0 is what is recommended by the DSM-5 for assessing psychiatric disability. This "test" contains 36 items or questions. For each item the *patients* rate themselves on a five-point scale according to how much difficulty they have had with the described situations in the past 30 days. Here are five of the questions. As you can see, all the questions have the same subjective and transparent quality.

1. Remembering to do important things?

2. Moving around inside your home?

3. Maintaining a friendship?

4. Doing your most important work/school tasks well?

5. How much have you been emotionally affected by your health condition?

In describing the WHODAS 2.0 on page xliii in the DSM-5's Preface the authors of the manual refer to it as,

> "a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine"

The DSM-5 then goes on to state that the WHODAS 2.0,

> "has been provided to replace the more limited Global Assessment of Functioning scale."



I don't know how anyone else feels about it, but for me it's a perfect example of the old "OUT OF THE FRYING PAN INTO THE FIRE" trick. Given human nature that typically tries to maximize gains, especially in lawsuits, it's like asking the fox to guard the chicken coop.

As a possible alternative to the WHODAS 2.0, the authors of the DSM-5 suggest two levels of "Symptom Measure" for adults. The first is found on pages 738 and 739 of the DSM-5 and is called the "DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure – Adult." This "Measure" is another five-point rating scale that asks the patients to rate themselves on 23 questions according to how much they have been "bothered" by their symptoms or complaints in the past two weeks.

Here are three of the questions. Once again, they all have the same subjective and transparent quality.

1. "Little interest of pleasure in doing things?"

2. "Feeling nervous, anxious, frightened, worried, or on edge?"

3. "Problems with sleep that affected your sleep quality over all?"

For those patients who are deemed to need additional investigation, page 737 of the DSM-5 suggests further "detailed clinical inquiry" by using "Level 2 Cross-Cutting Symptom Measures," which are only available on-line at www.psychiatry.org/dsm5.

Being naturally curious, I explored that site and discovered that for patients who are believed to be depressed the second level of measurement consists of another five-point self-rating scale with a grand total of eight questions, that also can be completed by an "informant" (shades of a TV crime series, I'm not kidding about the DSM-5 using the word "informant"). Here are three of the obviously subjective and transparent questions on which the patients rate themselves on their feelings during the past seven days.

1. "I felt sad." (I suppose that whoever wrote that question ignored page 168 of the DSM-5 that states, "periods of sadness are inherent aspects of the human experience.")

2. "I felt depressed."

3. "I felt unhappy."

At this point it appears appropriate to provide a few words about a concept few attorneys and claims adjusters know about, "psychometrics." Psychometrics is the part of psychology that deals with the design, administration and interpretation of quantitative tests used to measure such things as psychopathology, i.e., the disorders found in the DSM manuals. The first concern of psychometricians, who have even a cursory interest in forensic psychology, is creating a test that allows them to measure the individual's frankness and honesty. Since people undergoing psychological evaluations typically have something on the line besides their mental health, be it money or their freedom from incarceration, it is important that the test being used to measure their psychological status is actually doing so. Such a test is said to be valid. Put another way, a test is valid if it measures what it says it measures. The best-known and most valid test for measuring psychopathology is the MMPI (the Minnesota Multiphasic Personality Inventory). In its many versions it has been around since the 1930's. It's long term survival is largely a function of multiple validity scales that allow the person interpreting the test to determine if the patient is trying to present themselves in an overly favorable light or alternately, "faking," over-reporting pathology, exaggerating, embellishing, or, perish the word, Malingering. Unfortunately, there is not a single instrument in the DSM-5 for assessing psychiatric disability that is capable of measuring truthfulness. Thus, the bottom line here is that the DSM-5 has outlined techniques that are completely useless for assessing psychiatric disability in medical-legal cases.

Fourth, I would like to address the general issue of subjectivity in the DSM-5. By way of introduction, I would like the reader to know that I taught Abnormal Psychology at the university level for a number of years. In that course I carefully explained, to what were mostly college sophomores and juniors, the difference between "symptoms" and "signs." For those of you who never took that class, a "symptom" is synonymous with a "complaint," but a "sign" is something that can be observed, typically in the context of a psychological examination by a doctor. In discussing assessment issues and measures on page 733 of the DSM-5 the authors state,

> "*A dimensional approach depending primarily on an individual's subjective reports of symptom experiences along with the clinician's interpretation is consistent with current diagnostic practices."*
> (emphasis added)

Well, I don't know how you or anyone else will interpret this statement but to me the DSM-5 is saying that with regard to arriving at a diagnosis, "damn the diagnostic criteria, the objective psychological testing data and the doctor's observations," the patient's subjective reports or complaints and the doctor's subjective "clinical judgment" or interpretation rule the day.

The problem I have with all of the above issues is that the DSM-5 is "soft" when it comes to diagnoses. It doesn't seem to leave room for "hard" or objective measures found in face-to-face evaluations that include a Mental Status Examination and it certainly doesn't make a point of recommending any objective psychological tests that are known to quantify psychiatric problems. This is clearly in the spirit of the earlier mentioned diagnostic criteria being considered "guidelines" that is susceptible to being overridden by the doctors "clinical judgment." Overall, it is a rallying call for increased subjectivity in diagnostic assessments.

Fifth, I believe that the DSM-5 has taken an "in your face" approach to medical-legal or forensic issues. Specifically, on page 25 the authors noted that the DSM-5 diagnostic criteria were primarily designed to assist clinicians in conducting assessments, formulating an understanding of cases and planning treatment as well as being a reference "for the courts and attorneys in assessing the forensic consequences of mental disorders." However, after holding out that carrot to those of us working in the medical-legal area they then state,

> "As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of

clinicians, public health professionals, and research investigators *rather than all the technical needs of the courts and legal professionals.*" (emphasis added).

As I pointed out in last month's newsletter, California Labor Code section 3208.3 states that in determining if a worker has had a psychiatric injury the diagnosing practitioner is required to use the DSM-III-R or any "other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine." In this regard, while I do not know of any attempt to measure what has been accepted on a national level, this statement in the Labor Code, along with the "softness" and subjectivity that appears in the DSM-5 certainly raises the possibility that the DSM-5 is not going to be accepted nationally, leaving those of us to use the DSM-IV-TR.

So what's the takeaway? What can be done? Obviously, I cannot speak for anyone or about anything besides my self and my area of expertise but I believe that we need an entirely new system for dealing with psych claims. This system should be based on doctors conducting their examinations using objective diagnostic criteria, objective methods for assessing injured workers and a completely new and objective system for assessing and describing psychiatric disability. I also believe that there is no solution to the many problems in the existing system, not the least of which is SB863, which I plan to, but have yet to commented on. So the takeaway is my belief that any effective solution will have to be legislated. Unfortunately, the cynic inside of me tells me not to hold my breath!

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This is the fifty-fourth of a series of monthly newsletters aimed at providing information about psychological evaluations and treatment that may be of interest to attorneys and insurance adjusters working in the areas of workers' compensation and personal injury. If you have not received some or all of our past newsletters listed on the next page, and would like copies, send us an email requesting the newsletter(s) that you would like forwarded to you.