THE WETC PSYCHOLOGY NEWSLETTER

Dr. Bruce Leckart

"Find the Truth, Tell the Story"

Westwood Evaluation & Treatment Center
11340 Olympic Blvd., Suite 303, Los Angeles, CA 90064
310-444-3154, DrLeckartWETC@gmail.com, www.DrLeckartWETC.com

November, 2013
Volume 1, Issue 58

DSM-5: Say Hello to One of the New Disorders!

The American Psychiatric Association's DSM-5 was published at the end of May, 2013. It was produced by a committee of 283 Task Force members and an additional 1,203 advisors and other contributors, the vast majority of whom are doctors of one type of another. Unfortunately, its contents led it to be immediately rejected by tens of thousands of psychiatrists, psychologists and other mental health professionals from all over the world. Those "rejectors" have written and commented extensively about the major flaws in the DSM-5.

Just for review, ten of the major criticisms of the DSM-5 that are found in the recent literature are presented below. Many more can be found in my September, 2013 newsletter and on the Internet. Here they are:

1. The DSM-5 explicitly stated that a doctor's diagnosis could be based on a patient's complaints and the doctor's subjective judgments, in preference to objective diagnostic criteria.

2. The DSM-5 eliminated the Global Assessment of Functioning (GAF) Scale for assessing psychiatric disability and replaced it with the patient's subjective rating of their complaints.

One new DSM-5 mental disorder that will lead to more claims and litigation is Psychological Factors Affecting Other Medical Conditions (316).

3. The DSM-5's approach to forensic issues was to state very explicitly that the manual was not developed or intended to meet the needs of the courts.

4. The DSM-5 included untested new diagnoses with no known validity.

5. The DSM-5's creation of a new set of disorders and the replacement of objective criteria with patient's complaints and the doctor's subjective judgments has a net result of exposing large number of individuals to the potentially harmful effects of medication.

6. The DSM-5 defined normal reactions of people, such as grief over the death of a loved one, as psychopathology needing psychotherapy and psychotropic medication.

7. The DSM-5 defined characteristics of the normal aging process as psychopathological behavior needing treatment, which may be more harmful than beneficial.

8. The DSM-5 took an individual's everyday worries and concerns and turned it into psychopathology.

9. The DSM-5 redefined a variety of mental disorders so that a greatly expanded number of members of the population could now be judged to be mentally ill, requiring treatment, some of it with medications having potentially serious side effects.

10. By minimalizing the objective diagnostic criteria the DSM-5 opened the door to a plethora of litigation as well as insurance and disability claims that had previously been unthinkable.

The bottom line is that the DSM-5 has not been generally accepted by practitioners in the fields of psychiatry, psychology and other mental health professions. Those professionals have recognized that the DSM-5 has reduced the objectivity in psychological diagnoses, created disorders for which there is no scientific evidence, eliminated realistic methods of assessing psychiatric disability, and created a situation encouraging both over-diagnosis and the overuse of medication and other forms of treatment as well as draining economic resources most probably better used for other endeavors.

Although the critics of the DSM-5 indicate that the way it was written has created fertile ground for overpathologizing, this is not necessarily bad news for everyone. Depending on your viewpoint, one positive outcome of the new disorders and the reduced thresholds for diagnosis will be more litigation. Clearly, many medical-legal examiners and attorneys are quite happy with the DSM-5, particularly those professionals who feel they are not busy enough, i.e., not making enough money. Now they will have a lot more options for pursuing lawsuits and doing psych evaluations based on disorders that did not previously exist or that now have lower thresholds for their diagnosis. Additionally, many treating doctors will be happy with more patients to treat and more billings. Of course the insurance companies and the government will not be ecstatic since they will now have to pay more benefits. However, if history is any judge, they'll simply raise the premiums to cover their costs. So maybe the only people that can get hurt are the patients?

One new DSM-5 mental disorder that will lead to more claims and litigation is Psychological Factors Affecting Other Medical Conditions (316). Actually, this "diagnosis" has been around in one form or another since at least the DSM-III, which was published in 1980. In the DSM-IV and the DSM-IV-TR it was called Psychological Factor Affecting Medical Condition (316). Psychological Factor Affecting Medical Condition is correctly specified when a general medical condition is present and psychological factors or variables have been shown to adversely affect that general medical condition. However, in the DSM-IV and the DSM-IV-TR this is not a psychological or mental disorder and its specification is not relevant in legal jurisdictions requiring the diagnosis of a DSM-IV or DSM-IV-TR disorder. For example, in the California workers' compensation system a crucial issue in any litigation concerns determining if the applicant has had a psychiatric injury as the Labor Code defines that concept. In this regard, Labor Code section 3208.3 requires that in order for there to be a psychiatric injury, the individual must have suffered a mental disorder. Thus, since specifying the existence of Psychological Factor Affecting Medical Condition does not constitute the diagnosis of a mental disorder, its presence is not relevant to establishing the existence of a psychiatric injury and/or a psychiatric disability.

According to the DSM-5, Psychological Factors Affecting Other Medical Conditions (316) is correctly specified when there is a "medical symptom or condition" and psychological or behavioral factors have been shown to adversely affect that symptom or condition. The big difference between the DSM-IV and the DSM-IV-TR and the DSM-5, besides the addition of the word "Other" is that what was a condition that might have been the focus of clinical attention is now a mental disorder. As such, if one is litigating in a jurisdiction that requires the diagnosis of a disorder, what was formerly just something worth noting is now a full-blown, real mental disorder!

In addition to the above, it is interesting to note that according to the DSM-5 it is necessary for the doctor diagnosing this condition to demonstrate that psychological or behavioral

factors have been shown to adversely affect a medical condition. For example, let's say that a patient comes in for a psychological evaluation and is complaining of back pain. What information must the psychologist or psychiatrist have in order to conclude correctly that some psychological factor has affected the patient's back pain. Well, since most psychiatrists, and probably all psychologists, have not had training in orthopedics, they need medical records from a specialist in that area who has stated that not all of the patient's symptoms or complaints or signs are completely understandable from an orthopedic point of view. Without that information it seems very unlikely that a mental health professional could ever correctly conclude that a patient's pain was produced by something other than underlying physical pathology. So even though the status of this condition has been elevated to a "disorder" from a "condition" or non-disorder, it is still up to the non-mental health medical practitioners involved to provide evidence to support that diagnosis.

One little kicker that will delight plaintiff and applicant attorneys and keep defense attorneys up at night shaking their heads in dismay and talking to themselves is the provision in the DSM-5 that states that one of the psychological or behavioral factors that adversely affect the general medical condition is "poor adherence." In normal medical practice, this is alternately termed "non-compliance with medical treatment." For example, if a person has diabetes, or any other relatively easily treated general medical condition, and declines to take their medicine, up until now they have been said to be non-compliant and it is up to them to bear the risks of failing to accept and use known effective medical treatments. That used to be the end of the story. To wit, "Ms. Jones has refused to take her medicine and there is nothing further that I, as an endocrinologist, can do for her." Now, under the DSM-5, Ms. Jones's recalcitrance in the form of refusing to take her medicine, for God knows what reason, is a mental disorder that needs treatment and compensation. Of course, Ms. Jones is now completely off the hook for her behavior as she is officially "mentally disordered." I can hardly wait to see what the Social Security Administration does with these claims.

The net result is that the DSM-5 has created many more problems than it has solved and one is left wondering what motivated those 1,486 professionals to produce the contents of that diagnostic manual. Of course the cynical part of my personality cries out to me to consider that at least some part of their motivation was self-interest in obtaining more patient's for themselves and their colleagues and possibly continued support for their drug company and government funded research projects and honoraria.

BRUCE DR. LECKART
FORENSIC PSYCHOLOGIST

This is the fifty-eighth 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.