

THE WETC PSYCHOLOGY NEWSLETTER

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"Find the Truth, Tell the Story"

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DSM-5: Major Changes in Medical-Legal Cases

Thirteen years after the DSM-IV-TR was published in May, 2000 the DSM-5 was officially published on May 22, 2013. Essentially, the DSM-5 has the potential for far-reaching and major changes in medical-legal cases. Basically, if the DSM-5 is sanctioned for use in medical-legal cases, psychologists, psychiatrists, attorneys, government agencies and insurance companies will quickly discover they are dealing with a whole new world and exactly what will happen is quite uncertain. Here are just three questions, each of which identifies a major problem.

First, is the DSM-5 required to be used in workers' compensation cases? Second, given the content of the DSM-5 how will permanent psychiatric disability be measured? And third, will "clinical judgment" replace diagnostic criteria?

The first question, which relates to workers' compensation cases in California comes down to this, "Is the DSM-5 required for use by Labor Code section 3208.3?" For personal injury cases there is an analogous question, "Is the use of the DSM-5 required?" Similar questions apply to other medical-legal areas in every single venue in the English-speaking world. For the moment, let's stick with workers' compensation in California.

Essentially, does California Labor Code section 3208.3 require the use of the DSM-5? For those of you who are not familiar with that law, LC 3208.3 explicitly states:

"Basically, if put into practice, the DSM-5 will result in major changes in medical-legal cases by eliminating the GAF scores and WPI ratings, changing the diagnostic criteria for many disorders, reducing objectivity in clinical diagnoses, and giving doctors much greater freedom to use their subjective and unverifiable clinical judgments in arriving at diagnostic conclusions."

"A psychiatric injury shall be compensable if it is a mental disorder which causes disability or need for medical treatment, and it is diagnosed pursuant to procedures promulgated under paragraph (4) of subdivision (j) of Section 139.2 or, until these procedures are promulgated, it is diagnosed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine."

Since LC 3208.3 became law, there have been two revisions of the DSM-III-R, the DSM-IV and the DSM-IV-TR, respectively. In this regard, LC 3208.3 seemingly has been interpreted as requiring the use of both revisions. Presumably, the courts have agreed that the DSM-IV and the DSM-IV-TR were "diagnostic

manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.” However, the initial critiques of the DSM-5 indicate that this revision may not be “generally approved and accepted nationally by practitioners in the field of psychiatric medicine.” Nevertheless, that will be up to the courts to decide. What is clear is that if the DSM-5 is used it will be impossible to apply current workers’ compensation laws. Specifically, as discussed below, if one uses the DSM-5 conclusions about permanent psychiatric disability literally *cannot* be made. Similarly, conclusions about the presence or absence of a psychological disorder will become much more subjective. Sounds like a pretty dire situation to me.

Let’s now look at the second question, the permanent disability situation. In this regard, according to California’s current workers’ compensation laws, permanent psychiatric disability is assessed by converting the doctor’s determination of the Global Assessment of Functioning (GAF) score, expressed as a number between 0 and 100, to a Whole Person Impairment (WPI) rating, expressed as a percentage between 0 and 90. This method is required by the Schedule for Rating Permanent Disabilities that was published by the Department of Industrial Relations in January, 2005. **The major problem here is that there is no longer a GAF scale in the DSM-5! Yes, you heard correctly, there is no GAF Scale in the DSM-5.** Accordingly, if medical-legal examiners in psychology and psychiatry are required to use the DSM-5 they have no way of rating an individual’s permanent psychiatric disability. Think about that one for a while! Maybe after doing so you may come to the conclusion that the best way of rating permanent psychiatric disability is to go back to the Eight Basic Work Functions outlined in the now banished Psychiatric Protocols.

The third question involves the fact that the DSM-5 has created a problem with objectively arriving at clinical diagnoses. Forget for a moment that DSM-5 made some changes in the diagnostic criteria for disorders such as a Major Depressive Disorder, these are relatively minor problems when compared to what has happened to the definition of a mental disorder. Consider the following.

In the DSM-IV and the DSM-IV-TR a mental disorder is defined as:

“a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavior, psychological, or geological dysfunction in the individual.”

Here is the DSM-5 definition of a mental disorder:

“A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious,

or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above.”

Essentially, there is not much difference in the two definitions. In the DSM-IV-TR a disorder is characterized by “present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning).” In the DSM-5 a disorder is characterized by a “clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior.” Overall, the differences are relatively minor.

However, what is not minor is what the two diagnostic manuals say about the use of “clinical judgment” in arriving at a diagnosis. In the DSM-IV-TR there is the specification that,

“the exercise of clinical judgment may justify giving a certain diagnosis to an individual even though the clinical presentation *falls just short of meeting the full criteria for the diagnosis* (italics and underlining added) as long as the symptoms that are present are persistent and severe.”

But, in the DSM-5 here is what is said about “clinical judgment”:

“*Diagnostic criteria are offered as guidelines* (italics and underlining added) for making diagnoses, and their use should be informed by clinical judgment.”

The DSM-5 goes on to state:

“On the basis of the clinical interview, text descriptions, criteria and clinical judgment, a final diagnosis is made.”

My reading of these statements indicates that according to the DSM-IV-TR a diagnosis is correctly

assigned when the individual meets the diagnostic criteria outlined in the text unless the patient’s presentation “falls just short of meeting the full criteria for the diagnosis,” at which point, the clinician can apply their clinical judgment and arrive at a diagnosis. This appears to mean, for example, that if an individual presents with four signs or symptoms of a disorder that requires five signs or symptoms, the disorder can be diagnosed if clinical judgment indicates that it is the best and most appropriate way of describing the patient’s psychological status. Similarly, if the signs and symptoms are required to have been present for two weeks in order to make the diagnosis, but the clinician has found that they have only been present for a week or ten days, he or she is allowed to make the diagnosis anyway.

However, my reading of the DSM-5 indicates that the diagnostic criteria, are just one of the sources of information to be used. In fact, it appears that the DSM-5 has opened the proverbial door to the use of totally subjective feelings, thoughts and intuitions from the “clinical interview.” It also appears that the door has been opened to unfettered use of the diagnosing practitioner’s “clinical judgment,” which is not objective but subjective and not open to public inspection. To me this sounds like minimizing the diagnostic criteria in favor of the interviewer’s subjective impressions. It also makes me wonder if well-documented, reasoned and objective reports will be replaced by much more subjective and unverifiable documents that rely extensively, if not exclusively, on the evaluator’s “clinical judgment.” Overall, it sounds to me like an invitation to a chaotic party that abandons previously rigorous standards.

The bottom line or take away here seems to be that for those of us working in the medical-legal area, the DSM-5 appears to be a major step backward when it comes to providing a basis for objectively identifying mental disorders and objectively quantifying psychological or psychiatric disability. It will be very interesting

to see how the medical-legal community, including all the government agencies, insurance companies, attorney organizations, medical groups and other related mental health professionals deal with this issue.

So what's to be done? Well, two distinct possibilities come to my mind. First, it is possible that there will be a mandate that results in the mental health community continuing to use the DSM-IV-TR. Second, it is possible that we will all have to wait for the State of California to pass some new legislation defining a psychiatric injury and how permanent psychiatric disability is to be measured in the context of the DSM-5.

In summary, the long awaited and often delayed DSM-5 is finally here. Basically, if put into practice, the DSM-5 will result in major changes in medical-legal cases by eliminating the GAF scores and WPI ratings, changing the diagnostic criteria for many disorders, reducing objectivity in clinical diagnoses, and giving doctors much greater freedom to use their subjective and unverifiable clinical judgments in arriving at diagnostic conclusions. As for the other changes found in the DSM-5, my plan is to start providing information about them next month.

This is the fifty-third 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.