The Experience of Using DSM-III in a Court Clinic Setting: II Practicality and Effect of DSM-III on a Court Clinic's Work with the Legal System*

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Introduction

For the past several months, field trials of DSM-III have been in progress at several different clinical facilities across the country. These run the gamut of direct patient care providers, ranging from large, general inpatient units, through varied outpatient settings, to private practitioners' offices. Data gathered in these preliminary trials will be used to revise again the current working draft of DSM-III in preparation for the major field trials to begin in January under the sponsorship of NIMH. These are expected to last for more than a year and, somewhere near the end of the decade, should lead to the birth of DSM-III, an unruly and demanding child for which, it is hoped, we will all be able to accept some degree of responsibility.

Participants in these trials have been provided with copies of the latest revision of DSM-III (April 15, 1977) and are asked to place a number of patients seen in the ordinary course of business in the proper categories in both DSM-II and III. This information is recorded on diagnostic report forms which also solicit the examiners' view of the difficulty in applying the new diagnostic criteria and any suggestions he may have for improvement. Several groups within the Department of Psychiatry at the University of Rochester have taken part in these trials; one was the Sociolegal Clinic, which is located in the Hall of Justice and serves the criminal and family courts in Monroe County. Our purpose in participating was:

1. to study the feasibility of the new diagnostic process and to test its practical usefulness;
2. to suggest possible revisions of the Task Force on Nomenclature and Statistics, and finally,
3. to study the effect of the new nomenclature on our work with the legal system.

Methods

Thirty cases were evaluated by 2nd and 3rd year residents under our direct supervision. These cases were assigned in accord with routine Clinic

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procedure by professional staff independent of this project; *i.e.,* no effort was made to select particular cases for this exercise. All those evaluated had criminal charges pending, ranging from trespass to second degree murder, and were referred for examination either to determine competence to stand trial or to advise the court on disposition. The sample was made up of twenty-seven men and three women, ranging in age from 16 to 57. Unstructured interviews of about one hour's duration were carried out, and the diagnosis was then made by both DSM-II and DSM-III criteria. While this work was in progress, weekly conferences were held among members of the panel to discuss specific cases, focusing on the effect of differences in diagnosis between II and III on the offender's fate within the legal system. We hoped in this way to examine more closely the process by which the new diagnostic criteria will shape our thinking as well as that of our legal colleagues.

Results

At first, the new classification was deceptively simple to implement. Despite its mammoth size (350 pages), it is written in well-indexed, outline form and describes clearly the diagnostic categories, many of which bear a strong resemblance to their forebears in DSM-II. The tightly worded descriptions of the essential features of each disorder, followed by a list of operational criteria (the *sine qua non* for the particular diagnostic category), seemed to lend an air of precision and objectivity missing from DSM-II. On second look, however, we found the operational criteria to be disappointingly subjective in many instances; *e.g.,* the adjective "excessive" is often used to describe the degree to which a particular trait must be present in order to make a diagnosis. In other cases the diagnosis depends on factors unrelated to the presenting symptom picture; *e.g.,* age determines the diagnosis when an adolescent presents with signs of an antisocial personality disorder; between 15 and 18 he must be diagnosed undersocialized conduct disorder on the assumption that he may grow out of it (or grow into schizophrenia). Our fascination with the operational criteria was further dimmed by a blinding glimpse of the obvious fact that they were simply aids in ordering one's thinking about the data gathered in the clinical interviews; in no way did they confer on the diagnostician the vital ingredient of clinical judgment, nor did they substitute for the seasoned clinician's ability to elicit the signs and symptoms of mental disorder. Despite these shortcomings, the operational criteria are more explicit and denotative than the descriptive statements in II, and thus will exert considerable leverage in the direction of more reliable diagnoses.

Following this early disillusionment, we encountered our first practical problem in the use of the new manual. We saw that some of the residents were assigning the diagnosis under DSM-III by looking for the category most closely approximating the patient's diagnosis in II, hoping to force a match. For example, the question was asked, "What is explosive personality in DSM-III?" Then, primary data (signs and symptoms) would be distorted or unreasonably inferred as present in order to satisfy the operational criteria for diagnosis under III. This will be an important source of bias among all of us experienced with DSM-II. The best cure in our experience for this

understandable lingering with the familiar is an icy plunge into the 350 pages of DSM-III at the outset. More than a facile acquaintance is required before the new system can stand independent of its predecessor.

A second practical problem arose in connection with our use of Axes 4 and 5. Though they were to have been filled out in each case, they were often left blank. These axes are rough gauges of the psychosocial stress preceding the individual's decompensation (axis 4) and his premorbid level of functioning (axis 5). Both scales have seven points, with the lowest rating equivalent to be psychosocial stress contributing to the illness on axis 4 or superior adaptive function for several months during the previous year on axis 5. Thus a "high 4-low 5" (high stress, low premorbid disability) profile might be seen as a stereotype for good prognosis, while the reverse would tend to describe the chronically incapacitated patient and, in our setting, the likely recidivist. This would certainly be an over-simplification of the information contained in the two axes, but to the extent they are used at all, this may be an untoward consequence of the new classificatory system. Whereas there was lively interest in completing axes one and two, the residents viewed four and five as an externally imposed requirement for filling in yet another blank, a requirement of no heuristic value. They argued that this information was routinely elicited in the diagnostic interviews and just as routinely incorporated into diagnostic formulation and treatment planning. Thus, these axes were seen as satisfying someone else's need for data rather than contributing to diagnosis or patient care. Spitzer *et al.* speak to this when they say, "the purpose of the multi-axial approach is to insure that certain information of value in predicting outcome and planning treatment are *recorded* for each patient."[1] (I emphasize recording the data as opposed to eliciting it or using it clinically.) Here, the new manual seems to be aimed more toward the researchers' interest in standardizing psychiatric sub-populations than toward the clinician's interest in an understanding of the patient that will lead to effective treatment. Our experience suggests that in practice axes four and five will wither away to become mere vestigial appendages of the new nomenclature. It should be noted here that axis three (non-mental disorders directly relevant to psychiatric disturbance) calls for an entry only infrequently and is likely to be viewed as a curiosity rather than as a vital part of the diagnostic formulation.

A practical advantage of the new system came to light in the course of our work: the list of "non-diagnoses" has been expanded and more descriptively headed "conditions not attributable to a known mental disorder." Included herein are such categories as adult antisocial behavior, malingering, marital problems, *et al.* We are encouraged to use this section for behavior which led to contact with the mental health care system, when there is insufficient evidence to justify diagnosis of any of the mental disorders. This expanded list will allow us to make note of the presenting problem without "reaching" for psychiatric diagnoses or ignoring disturbing behavior by offering what is construed as a clean bill of health (*i.e.*, a diagnosis of No Mental Disorder). We are advised to use this latter category only when a full psychiatric evaluation reveals no evidence of disorder. Thus, this category becomes an "affirmative" diagnosis, rather than a wastebasket for incomplete diagnostic

studies. Lest we become overly cautious in diagnosing disorder, however, we are instructed to do so even when it is only "clinically probable that the patient meets the operational criteria."

Not surprisingly, we came up with quite similar diagnoses of our patients under DSM-II and III. In two cases, the defendant's age (less than 18) precluded the use of antisocial personality disorder in III, the classification assigned to both under II. In both instances the diagnosis became, instead, undersocialized conduct disorder, a term which, despite its alien ring, will likely mean no more nor less to our legal colleagues than its cognate, antisocial personality disorder. The requirement to satisfy the operational criteria generally resulted in more conservative diagnoses; *e.g.*, alcohol addiction became alcohol abuse in one instance. But in another case the relatively innocuous diagnosis of inadequate personality was transposed to antisocial personality. This could best be understood by considering two factors: (1) antisocial personality disorder in II is not identical to its counterpart in III; particularly important is the stress laid in the new manual, as a result of Robins' work, on the origin of this disorder in childhood; (2) more generally, the pithy descriptions of the diagnostic entities in II allow much more room for fitting the patients into one's own idiosyncratic conception of the disorder. (We come to DSM-II with knowledge of the cardinal features of, let's say schizophrenia, already formed. When we pick up the new manual, however, we find that the clinical data must meet certain sharply delimited requirements before we can use that familiar old label.) As we reviewed the few minor diagnostic changes between II and III in our thirty cases with our legal colleagues, it became clear that whatever DSM-III's impact on the legal setting, it will not result from these differences.

The question then arose "Will DSM-III have any effect on the legal system?" Since we offer actual diagnoses to the court only infrequently and since the legal tests for the various required mental capacities are unchanged, it would seem at first blush the answer may be in the negative. However, we are persuaded this will not be the case for two reasons. (1) The demands of the new taxonomy upon psychiatrists are formidable; those who scrupulously meet the requirements for assigning patients to diagnostic categories under DSM-III will have organized their clinical observations within a rigorous and standardized framework. Diagnosis as a dynamic process is emphasized. This will stimulate critical thinking about etiology and treatment approaches whether we are concerned, as clinicians, with an N of 1 or, as researchers, with large standardized subgroups of psychiatric patients. (2) By the same token, those in other disciplines who become familiar with the more objective operational criteria for establishing and delimiting the diagnostic categories may reasonably assume a higher order of confidence in our diagnostic work. Some of the hue and cry around the unreliability of our classificatory system may abate. At the very least the still skeptical attorney will have for the first time an explicit text, complete with operational criteria, to guide his questioning. This cannot help but raise the quality of the dialogue between us.

Conclusion

In summary, our experience with the new manual was both challenging

and educational. DSM-III is first an imposing text on taxonomy, and only then a list of labels. Careful study, to include courses for residents and other mental health professionals, will be necessary to insure its effective use. While the most visible result of the diagnostic process (*i.e.*, the label) was much the same under DSM-II and III, the demanding process involved in the use of III stimulated much careful, critical thinking, both among ourselves and among our legal collaborators. It will continue to be our responsibility to introduce the new manual as a development of far-reaching significance in our field; to give it short shrift would be to pass up an exciting development in psychiatry with far-reaching implications for generating clinically useful knowledge and for rejuvenating our collaborative work with other related professions. We encountered no major problems in applying DSM-III once we steeled ourselves sufficiently to become familiar with this tome. We anticipate that Axes 3-5 will be used irregularly at best, since they are seen (by at least one group of practitioners) as providing only a more elaborate description of the patient, while generating no additional data useful in his care. On the positive side, the expanded list of conditions not attributable to mental disorder, and the clearly defined operational criteria (for most diagnoses) go a long way toward offering a more rational classificatory system than those we have used in the past. Perhaps when we offer a diagnosis under DSM-III, we will less often be scolded for speaking as Humpty Dumpty when he said to Alice "When I use a word, it means just what I choose it to mean – neither more nor less."

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