The Experience of Using DSM-III in a Court Clinic Setting: I Basic Changes in the Methodology of Psychiatric Diagnosis*

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Introduction

The American Psychiatric Association has given the organization's Task Force on Nomenclature and Statistics the mandate to develop a new Diagnostic and Statistical Manual (DSM-III). DSM-III is to reflect the latest available knowledge and, as a secondary concern, is to be devised in a way that permits it to be related to the International Classification of Disease (ICD 9). ICD 9 is to go into effect throughout the world in January of 1979; the APA Task Force plans to have DSM-III ready shortly thereafter. The purpose of this paper is to describe the basic changes in the methodology of psychiatric diagnosis which DSM-III requires of its users.

Increased Number of Categories in DSM-III

There have been a number of criticisms and admonitions that medical classificatory schemes are artificially imposed upon nature and should be dismissed. However, medical taxonomies have proven extremely valuable in our efforts to decrease suffering and disability and to further our understanding of underlying processes. Hippocrates (466-377 B.C.) is credited with introducing psychiatric syndromes into the province of medicine.[1] Hippocrates and Aristotle believed that there was a single mental abnormality which had different presentations. Menninger[2] supports this unitary concept of mental illness. The Platonic school believes that discrete entities existed, although their borders might be fuzzy and their symptoms might overlap. Kraepelin, who had a major influence on psychiatric classification, also believed that there were many discrete entities.

DSM-III appears to be in the Platonic-Kraepelinian tradition. There is a sharp increase in the number of conditions listed in DSM-III as compared with the number listed in DSM-II. The APA Task Force states that DSM-III is to be inclusive, *i.e.*, "when a clinical condition can be described with clarity and relative distinctness, it is considered for inclusion."[3]

DSM-III and the Medical Model

Medical classification has many uses and must be broadly applicable. For

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the clinician, the classification must aid in his therapeutic planning; for the investigators, the classification must assist in creating discrete groups for comparison. Spitzer[3] views the DSM-III as consistent with the medical model, not the old biomedical model but the biopsychosocial medical model described by Engel.[4] Engel reminds us that for many medical disorders, a single sufficient and necessary cause is unlikely; what usually is involved is a complex interaction of biologic, intrapsychic, and environmental events.

Use of the Term "Disorder"

The term "disorder" is used to refer to each of the sections of DSM-III because it is viewed by the Task Force as a general term which is applicable to all conditions listed in DSM-III. The disorders are grouped according to etiology, when known. If an etiology is unknown or unclear, the classification is dependent upon phenomenologic and natural history characteristics, as occurs in the rest of medicine. DSM-III avoids the imperialistic, impractical and inaccurate view that all individual and societal problems are psychiatric illnesses. Antisocial behavior, for example, must be persistent and associated with serious impairment in interpersonal relationships and occupational functioning before fulfilling the criteria of a diagnosis of Antisocial Personality Disorder.

Operational Criteria

DSM-II contains brief, often vague definitions of diagnostic categories. DSM-III contains extensive descriptions of the disorders. There are operational criteria which use specific inclusion and exclusion criteria for each diagnosis. As Feinstein has written, "the production of operational identification has been a pioneering, unique advance in nosology."[5] This advance will lead to an increase in the inter-observer reliability of psychiatric diagnosis, *i.e.,* increase the likelihood that different psychiatrists will arrive at the same diagnosis. It is clear that this result will have a salutary effect on the "battle of experts." In addition, DSM-III provides the psychiatrist with a framework for structuring a description of the clinical data and the clinical reasoning underlying the psychiatric diagnosis. While it may be argued that attorneys and judges are concerned only with signs and symptoms, diagnostic labels in and of themselves often have an effect on the decisions made by the legal system.

Multiaxial Framework

DSM-III, unlike DSM-II, incorporates a multiaxial framework which seeks to encourage the recording of information which is useful in predicting outcome and planning treatment. DSM-III has five axes. Axis I is used for Clinical Psychiatric Syndromes. Axis II is used for Personality Disorders in adults and specific Developmental Disorders in Children. Axis III is used to record Non-Mental Medical Disorders. Axis IV is used to judge the severity of Psychosocial Stressors. Axis V calls for the clinician to evaluate the patient's Highest Level of Adaptive Functioning in the Past Year. These parameters, which have always been a part of a thorough psychiatric evaluation, will become the general expectation of every complete psychiatric diagnosis.

Discussion

DSM-III represents the latest of many attempts to improve psychiatric nosology and the diagnostic process. As Judge Bazelon has pointed out, "psychiatry must be prepared to face ambiguity and uncertainty in psychiatric reports. Psychiatric diagnoses are uncertain because a clinical diagnosis is not a scientific fact but an educated guess. Its reliability depends on the investigation and reasoning that underlie it."[6] We must avoid overstating the extent of our knowledge and the certainty of our clinical reasoning, diagnoses and prognoses. Freed from the burdens of having to be omniscient, we can make realistic contributions to legal proceedings while we continue to strive to expand our understanding of psychopathology – its etiology, course and treatment.

References

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