Davis Lecture, April 28, 2015

DSM-5 Changes in Child Diagnosis: Social, Policy, and Forensic Implications
(aka Psychiatric Diagnosis and Social Justice: How psychiatry became pharmacological social work)

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GPHAP (Graduate Program in Health Administration and Policy) Class of 1963
• From DSM-1 to DSM-5
• Radical change in psychiatric diagnosis as well
• Also more inclusive, maybe in not as good a way, as diagnosis expands to cover more areas of human emotion and functioning
Two topics of talk today

• Interaction of details of DSM-5 diagnostic criteria for child and adolescent disorders with legal, social, policy, and forensic issues

• Interface of diagnostic criteria with the challenge of social justice ("psychological justice")
Child diagnostic criteria and social policy
Neurodevelopmental Disorders
Intellectual Disability (Intellectual Developmental Disorder)
Intellectual Disability (Intellectual Developmental Disorder)

- Formerly called “Mental Retardation” – this term is no longer used because of stigma and because of legal requirements (in alignment with ICD, American Association on Intellectual and Developmental Disabilities, and US Department of Education)
- Rosa's Law replaced instances of “mental retardation” in laws and official business with “intellectual disability.”
- “Intellectual developmental disorder” will/may be used after ICD-11 emerges, now in parentheses
Intellectual Disability

DSM-IV definition of mental retardation:

- Significantly subaverage intellectual functioning: an IQ of **approximately 70 or below** on an individually administered IQ test
- Deficits or impairments in present adaptive functioning **in at least two areas:** communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
- SO BOTH IQ AND FUNCTIONING, but weak functional criteria, IQ did most of the work
# Intellectual Disability

## DSM-IV-TR Severity Levels

<table>
<thead>
<tr>
<th>Severity</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Mild</td>
<td>IQ level 50-55 to approximately 70</td>
</tr>
<tr>
<td>Moderate</td>
<td>IQ level 35-40 to 50-55</td>
</tr>
<tr>
<td>Severe</td>
<td>IQ level 20-25 to 35-40</td>
</tr>
<tr>
<td>Profound</td>
<td>IQ level below 20-25</td>
</tr>
<tr>
<td>Severity unspecified</td>
<td>Used when strong presumption of MR but person’s intelligence is untestable by standard tests</td>
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DSM-5 Changes to Intellectual Disability

- Diagnosis based on IQ plus dimensional assessment in three domains, with impairment requiring support (due to intellectual deficits) in at least one domain required:
  - conceptual domain (e.g., reading)
  - social domain (e.g., interaction with peers)
  - practical domain (e.g., ability to care for self)

- Severity levels are separately coded and are now evaluated only by adaptive functioning, not IQ level, with a chart offering guidelines for severity levels, calibrated to support needs.
DSM-5 Intellectual Disability

• “Approximately 70” IQ cutoff in DSM-IV has been elaborated in the text of DSM-5 in terms of standard error of the mean (SEM), as in many state laws.
  – Individuals with intellectual disability have scores of approximately two standard deviations or more below the population mean, including a margin for measurement error (generally +5 points). On tests with a standard deviation of 15 and a mean of 100, this involves a score of 65–75 (70 ± 5)

• Addresses problems where “bright line” boundary can mistakenly lead to execution, i.e., Atkins vs. Virginia (IQ between 71-80)
Eleven years ago, the Supreme Court banned the execution of intellectually disabled people in *Atkins v. Virginia*. Ever since, some states have worked to circumvent that ruling by defining intellectual disability using unscientific standards or by making it nearly impossible to prove. On Monday, the justices indicated that they may at last be ready to clarify the Atkins decision by agreeing to consider whether a Florida law defines intellectual disability too narrowly.
Bright line versus standard error

- Some states have been using a bright line criterion (i.e., precise IQ cut-off) and some have allowed the standard deviation around the theoretical cut-off.
- Bright line criteria have recently been ruled unconstitutional because of threat of executing someone who is in fact ID due to SEM.
- However, lack of a bright line can cut both ways. Texas has no bright line and allows a 5-point-either-way error, but uses this to allow executions – and has highest execution rate in the country.
Intellectual Disability and Forensics: The Death Penalty

Supreme Court Atkins v. Virginia; executing the mentally retarded violated the Constitution’s prohibition against cruel and unusual punishment.

• The court left it up to states to define intellectual disability. Broadly followed DSM.

Freddie Hall

• Bright line IQ issue.

• Recent Supreme Court decision on Florida case: “Florida seeks to execute a man because he scored a 71 instead of a 70 on an IQ test,” Kennedy wrote. May 2014 decision.

• Importance of SEM clarified in DSM-5.

Adaptive functioning

• DSM-IV quite vague

• Texas Briseno factors – adaptive functioning

• Marvin Lee Wilson case – IQ 61, many deficits, psychologist said qualified as ID, but preponderance of evidence under Briseno factors used to affirm death penalty (e.g., due to criminal history).

• DSM-5 elaborates and clarifies adaptive functioning, separates severity from IQ.
Texas Briseno decision

• “We, however, must define that level and degree of mental retardation at which a consensus of Texas citizens would agree that a person should be exempted from the death penalty. Most Texas citizens might agree that Steinbeck’s Lennie 19 should, by virtue of his lack of reasoning ability and adaptive skills, be exempt. But, does a consensus of Texas citizens agree that all persons who might legitimately qualify for assistance under the social services definition of mental retardation be exempt from an otherwise constitutional penalty?” (p. 6)
Briseno factors, decided by preponderance of evidence

• “• Did those who knew the person best during the developmental stage—his family, friends, teachers, employers, authorities—think he was mentally retarded at that time, and, if so, act in accordance with that determination?
• • Has the person formulated plans and carried them through or is his conduct impulsive?
• • Does his conduct show leadership or does it show that he is led around by others?
• • Is his conduct in response to external stimuli rational and appropriate, regardless of whether it is socially acceptable?
• • Does he respond coherently, rationally, and on point to oral or written questions or do his responses wander from subject to subject?
• • Can the person hide facts or lie effectively in his own or others’ interests?
• • Putting aside any heinousness or gruesomeness surrounding the capital offense, did the commission of that offense require forethought, planning, and complex execution of purpose?” (pp. 8-9)
“Mice, Men, and Mr. Steinbeck (NY Times, Dec 5, 1937)

• In 1937, the novelist himself told The New York Times that the model for his character, a killer who did not comprehend his own actions, was shown leniency by the American legal system of the time. “Lennie was a real person,” Mr. Steinbeck said. “He’s in an insane asylum in California right now. I worked alongside him for many weeks. He didn’t kill a girl. He killed a ranch foreman. Got sore because the boss had fired his pal and stuck a pitchfork right through his stomach. I hate to tell you how many times I saw him do it. We couldn’t stop him until it was too late.”
Briseno—Thomas Steinbeck Letter

• “After Thomas Steinbeck, the writer’s son, read a Guardian article on how his father’s novel had been used in a Texas court to argue for the execution of the mentally retarded, he joined the effort to halt the killing of Mr. Wilson, The Beaumont Enterprise reported. In a statement released on Tuesday, just before Mr. Wilson was put to death for a fatal shooting in 1992, Mr. Steinbeck wrote:

• ‘On behalf of the family of John Steinbeck, I am deeply troubled by today’s scheduled execution of Marvin Wilson, a Texas man with an I.Q. of 61. Prior to reading about Mr. Wilson’s case, I had no idea that the great state of Texas would use a fictional character that my father created to make a point about human loyalty and dedication, i.e., Lennie Small from “Of Mice and Men,” as a benchmark to identify whether defendants with intellectual disability should live or die.

• My father was a highly gifted writer who won the Nobel Prize for his ability to create art about the depth of the human experience and condition. His work was certainly not meant to be scientific, and the character of Lennie was never intended to be used to diagnose a medical condition like intellectual disability. I find the whole premise to be insulting, outrageous, ridiculous and profoundly tragic. I am certain that if my father, John Steinbeck, were here, he would be deeply angry and ashamed to see his work used in this way. And the last thing you ever wanted to do, was to make John Steinbeck angry.’”
Autism Spectrum Disorder

• Plea to reduce categories, dimensionalize
• Rates increased from 1/2000 to 1/50 after linked to services, sometimes specific to this diagnosis
• DSM-5 Autistic Spectrum narrows definition- not clear how much
Encompasses
- autistic disorder
- Asperger’s disorder
- childhood disintegrative disorder
- pervasive developmental disorder not otherwise specified
- Rett’s disorder

Based on the theory that Asperger’s is a mild form of autism – plausible from symptom descriptions, but not agreed to by everyone in the field

Diagnosis requires deficits in social communication and repetitive behavioral patterns rated along a dimension of severity
ASD dimensions

• In DSM-IV, Aspergers was assessed in two domains of social interaction and repetitive/stereotypical behavior.
• DSM-IV Autistic Disorder assessed also on third dimension of communication.
• In DSM-5™ Autism Spectrum Disorder, social interaction and communication criteria are combined into one social communication and social interaction dimension.
• Kept the repetitive stereotypic behavior dimension.
• So, total of two dimensions for all autistic spectrum disorders.
Autism Spectrum Disorder

- **Persistent deficits in social communication and social interaction**
  (All; as in Asperger’s, this replaces two autistic disorder categories of impairment in social interaction and impairment in communication)
  - Deficits in social-emotional reciprocity
  - Deficits in non-verbal communication
  - Deficits in developing and maintaining relationships
- **Restricted repetitive behaviors or interests (2 of 4)**
  - Stereotyped behavior or speech
  - Need for sameness and routines
  - Abnormal fixations or restricted interests
  - Hyper- or hyporeactivity to sensory input
- **Spectrum of severity provided**
- **Specify current severity for Criterion A and Criterion B:** Requiring very substantial support, Requiring substantial support, Requiring support
## Severity of Social Communication deficits

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Anchor</th>
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<tbody>
<tr>
<td>Level 3</td>
<td>Severe deficits; very little initiation of social interactions and minimal response to others: e.g., few words or intelligible speech, makes unusual approaches only to meet needs</td>
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<tr>
<td>Level 2</td>
<td>Marked deficits; e.g., speaks simple sentences, interaction limited to narrow special interests</td>
</tr>
<tr>
<td>Level 1</td>
<td>Without supports in place, deficits cause noticeable impairments; e.g., able to speak in full sentences but conversation fails</td>
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Autism Spectrum Disorder/Aspergers Disorder Controversies

• Loss of Asperger’s as a distinct category
  – Rare example of destigmatized category (‘Aspies’ who claim Einstein had Asperger’s, popular TV characters)
  – Concern about being put into same boat as more ill autistic patients, increasing stigma

• But: False positives of people who are eccentric/different?
DSM-IV Asperger’s vs DSM-5 ASD

**DSM-IV**

- A. Qualitative impairment in social interaction, as manifested by at least **two** of the following:
  - (1) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
  - (2) failure to develop peer relationships appropriate to developmental level
  - (3) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
  - (4) lack of social or emotional reciprocity

**DSM-5**

- A. Persistent deficits in social communication and social interaction **across multiple contexts**, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
  - 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions. (=4)
  - 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication. (=1)
  - 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers. (=2)
DSM-IV

• B. Restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
  • (1) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
  • (2) apparently inflexible adherence to specific, nonfunctional routines or rituals
  • (3) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
  • (4) persistent preoccupation with parts of objects

DSM-5

• B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
  • 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
  • 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
  • 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
  • 4. Hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).
Grandfathering ASD (cont)

• The main concern was that changes in diagnostic thresholds at the milder end of the spectrum would eliminate some from diagnosis and lead to loss of services, to which these diagnoses are closely tied.

• Some studies suggested possible loss of substantial numbers of cases of Asperger’s and also of some autism cases.

• Solution: grandfathering in all previous diagnoses to avoid loss of services (!):

• “Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger’s disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder.”
Social (Pragmatic) Communication Disorder

- New diagnosis in DSM-5™
- Persistent difficulty with verbal and non-verbal communication for social purposes (not explained by autism spectrum disorder)
- Formerly diagnosed under PDDNOS, leading to inconsistent treatment which can be effective
- Asperger’s cases would not fit here because no restricted stereotyped interests as in ASD
Attention-deficit/hyperactivity disorder (ADHD)

• Several lines of evidence support overdiagnosis of child ADHD

• Failure to address demonstrated problems
ADHD – a major false positives problem

• The evidence is overwhelming that attention-deficit/hyperactivity disorder (ADHD) is highly overdiagnosed.
• Of children in a given school grade, the youngest children have much higher rates of ADHD diagnosis (Elder, 2010; Evans et al., 2010; Zoëga et al., 2012), suggesting that normal variations in developmental rate are being mistaken for disorder.
• ADHD kids have higher rates of normal genetic variants that produce novelty seeking behavior and less tolerance for boredom, found at higher rates in nomadic populations (Eisenberg et al., 2008).
• Brain development studies reveal slower development of inhibitory control in ADHD kids but no abnormal brain growth (Sripida et al., 2014; Shaw et al., 2007).
• Diagnostic rates vary dramatically with school system administrative changes and incentives (Hinshaw).
• Yet, instead of trying to refine the diagnostic criteria to address a massive false-positives problem, the DSM-5 instead altered the ADHD criteria to facilitate expanding diagnosis to adults, which risks perpetuating the same high false positive rate among adults as well by encompassing normal variation within disorder.
Attention-Deficit/Hyperactivity Disorder – changes to ease diagnosis in adults

- Age of symptom onset requirement raised from age 7 to age 12
  - Rationale for change: individuals often cannot recall onset before age 7; later “onset” cases the same as earlier age. Criticism: if it’s a developmental disorder, it ought to emerge early

- Diagnosis in adolescents and adults requires only five symptoms, rather than the six in DSM-IV

- Examples adjusted to illustrate adult ADHD
ADHD: reduction of impairment threshold

DSM-IV (p. 84)
• B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before age 7 years.
• C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).
• D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning.

DSM-5 (p. 60)
• B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years.
• C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings (e.g., at home, school, or work; with friends or relatives; in other activities).
• D. There is clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning.
Attention-Deficit/Hyperactivity Disorder

- b. Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- e. Often has difficulty organizing tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
f. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).

g. Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).

i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).....
Specific Learning Disorder
Specific Learning Disorder

- New overarching category that replaces and combines all the DSM-IV learning-disorder diagnoses
- Specifiers indicate specific problem areas (but still must be coded separately due to ICD coding)
- Reflects the fact that these disorders often occur together
Specific Learning Disorder

- Abandonment of the IQ/performance discrepancy approach
- DSM-IV required a disparity between level of achievement in the problem area and overall IQ in order to establish a learning disorder vs. poor ability.
- This requirement is eliminated in DSM-5.
- Instead, performance is compared to average expectations for one’s age: “The affected academic skills are substantially and quantifiably below those expected for the individual’s chronological age.”
- Why? Changing federal regulations now prohibit the diagnosis of learning disorder that determines support for services from requiring a difference between disorder-specific learning and overall IQ. The reason is that this approach disadvantages groups that score lower on IQ tests, who then find it harder to be diagnosed with learning disabilities and to receive services.
Specific Learning Disorder

- Also, DSM-5 adopts the “response to intervention” (RTI) approach: a trial test of educational interventions is required in order to demonstrate the problem is not easily ameliorable by the provision of standard educational interventions targeting the difficulties, thus that the child requires special services.

- “Difficulties learning and using academic skills...despite the provision of interventions that target those difficulties”

- Opponents claim that RTI simply identifies low achieving students rather than students with learning disabilities
• At the root of all these diagnostic changes is a sense of justice for children.
Two kinds of mandated professional tasks

- Essential tasks—aimed at the profession’s “organizing value”
- Derived tasks—utilizing the profession’s skills but aimed at other values (e.g., cosmetic surgery)
- Psychiatry/mental health professions: essential task is treatment of mental disorder
- Social work: minimal distributive justice/safety net/”social minimum” (Rawls)
It is important to recognize that although treatment of mental disorder is the essential task of the mental health professions, they have several other functions; they are not only about mental disorder

- The DSM’s “V Codes,” *greatly expanded in DSM-5*, acknowledge this by listing non-disordered conditions for which psychiatrists are commonly consulted, such as normal bereavement, marital or parent-child conflict, and occupational or academic problems.
- I would argue that “psychological justice” plays a large role in what we treat

Figure 1. The diagnostic spectrum.
The symptom-based criteria addressed many of the problems facing psychiatry in the 1960s-1970s

- Unreliability (US/UK) and Rosenhan studies/operationalized criteria
- Theoretical tower of Babel/theory neutrality
- Psychoanalytic theoretical assumptions/theory neutrality
- Anti-psychiatry (Szasz, Scheff, Foucault)/definition of disorder and operationalized criteria
- Soviet dissidents (injustice)/definition of mental disorder
- Midtown Manhattan Study/need to define specific disorders
- Pharmaceutical targets/specific disorders
• But simply formulating criteria for some problematic condition does not make the condition a disorder
The etiology and treatment of childhood

Jordan W. Smoller, University of Pennsylvania
Journal of Polymorphous Perversity

Childhood is a syndrome which has only recently begun to receive serious attention from clinicians…. Clinicians are still in disagreement about the significant clinical features of childhood, but the proposed DSM-IV will almost certainly include the following core features:

- Congenital onset
- Dwarfism
- Emotional lability and immaturity
- Knowledge deficits
- Legume anorexia
DSM-5 Definition of 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.
Disorder as "Harmful Dysfunction" (Wakefield, 1992)

- A dysfunction is a failure of an internal mechanism to perform one of its natural functions (as ultimately determined by evolutionary design).
- A dysfunction is a disorder if it causes harm, as defined by social values.
Challenge of dysfunction

• Establishing the presence of dysfunction is necessarily inferential and speculative because of the lack of knowledge of internal psychological and biological processes and their functions and dysfunctions.

• Given that virtually every psychiatric symptom characteristic of a DSM disorder can occur under some circumstances in a normally functioning person, diagnostic criteria based on symptoms must be constructed so that the symptoms indicate an internal dysfunction, and are thus inherently pathosuggestive.

• The inference will never be airtight.
Some of the strategies used in DSM to identify mental disorder

- Requiring a minimum duration and persistence
- Requiring that the intensity of a symptom exceed that seen in normal people
- Requiring disproportionality of symptoms to contextual triggers
- Requiring pervasiveness of symptom expression across contexts
- Adding specific exclusions for contextual scenarios in which symptoms are best understood as normal reactions;
- Requiring enough symptoms from an overall syndrome to meet a minimum threshold of pathosuggestiveness.
Examples of DSM-5 addressing false positives

- Insomnia disorder: added ‘The sleep difficulty occurs despite adequate opportunity for sleep.’
- Oppositional defiant disorder: excludes diagnosis if the defiant behaviour is directed only at a sibling.
- Sexual dysfunction: added ‘The sexual dysfunction is not better explained. . .as a consequence of severe relationship distress (e.g., partner violence) or other significant stressors’
The “false positives” problem in DSM-5

• “Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and 'behavioral addictions' will soon be mislabeled as psychiatrically sick.” (Frances, 2012)
The clinician’s dilemma

• The over-extension of DSM diagnosis gives rise to an ethical and clinical issue: how should the clinician handle the many cases where a DSM diagnosis of disorder is possible by the criteria but where the individual is in fact not suffering from a mental disorder?
Looking at false positives from both sides now

• Threat to human freedom
• Extension of diagnostic system to address psychological injustice
Is psychiatry engulfing social work’s traditional terrain?
Clinical Significance Criterion (CSC)

- The CSC was the vehicle by which social role performance became an arbiter of psychiatric diagnosis throughout the manual.
The CSC

- The DSM-5 makes extensive use of the “clinical significance criterion” (CSC) as a requirement for diagnosis. It generally states:
  - “the symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (p. 161).
- Introduced into most categories of disorder in the DSM-IV
- Justified by the reference in DSM-IV’s definition of mental disorder to “present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning)” (1994, p. xxi).
- Reaction to surprisingly high rates of disorder prevalence reported in epidemiological surveys using DSM symptom-based criteria.
Concerns about the CSC

• The WHO’s International Classification of Disease (ICD) attempts to separate diagnosis of disorder by symptoms from assessment of social functioning by role impairment to prevent confusing failure to meet social demands (e.g., by immigrants) with mental disorder.

• Normal conditions often meet the CSC (e.g., normal distress, and normal impairment, as in grief)

• The CSC is often redundant; satisfying symptom criteria virtually guarantees satisfaction of the CSC.

• The CSC is tautological; what is “clinically significant” can only be determined by knowing whether there is a disorder.

• The CSC is the wrong diagnosis of what is wrong with DSM-criteria; it is not the level of harm but the dysfunction that is the problem.
The CSC

- However, the CSC has come to have a major impact via another route, where dysfunction is not assured.
Social Role Impairment as a Criterion for “Other Specified” Disorder
“Other Specified”

• The CSC was introduced as an additional necessary “harm” requirement to reduce diagnosis.

• Ironically, the CSC has been transformed into virtually a sufficient condition with minimal symptom requirements for diagnosis.
“Other Specified”

• This expansion occurs in the “miscellaneous” diagnostic categories that are used to diagnose conditions that do not fit under any of the manual’s standard categories.

• In DSM-IV, there were miscellaneous categories for each type of disorder labeled “disorders not otherwise specified” (NOS), (e.g., “depressive disorders not otherwise specified”).
“Other Specified”

• In DSM-5, NOS categories have been replaced by two new categories: “other specified disorder” and “unspecified disorder” (e.g., “other specified depressive disorder”; “unspecified depressive disorder”). “Other specified” diagnosis requires the clinician to explain why the condition does not meet standard criteria (e.g., a depressive condition has too few symptoms to meet the usual 5-symptom threshold), whereas “unspecified” requires no explanation, just the clinician’s judgment.
NOS Split Into Two Categories in DSM-5

- ______ Disorder Not Otherwise Specified
- Other Specified ______ Disorder
- Unspecified ______ Disorder
“Other Specified”

- These categories generally include no specific diagnostic criteria or diagnostic thresholds, just reference to the kinds of symptoms.
- For example, guidelines for “other specified” and “unspecified” ADHD explain:
  - “This category applies to presentations in which symptoms characteristic of attention-deficit/hyperactivity disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for attention-deficit/hyperactivity disorder” (American Psychiatric Association, 2013, pp. 65-66).
- Yet studies show that such symptoms are widespread.
“Other Specified”

• “Other specified” guidelines do not mention the requirement in DSM-5’s definition of disorder that symptoms must be due to an underlying dysfunction. Rather, role impairment is characterized as sufficient for disorder given any symptoms.

• These categories allow role impairment to become a virtually sufficient criterion for disorder.

• This use of social role performance has no plausible rationale as an approach to diagnosing psychiatric disorder.

• However, it does make some sense as a way to address unfairness of opportunity due to mismatches between individuals’ natures and social demands – that is, it is social work!
Disadvantages of putting everyone who needs help into the sick role

• Especially in an era gripped by the ideology that all mental disorder is “brain disease”
Alternative: Psychological Justice

• Expand the domain of publicly supported treatment based on a moral rationale other than medical necessity
Norman Daniels

• Healthcare is special because it preserves a normal range of opportunities, and equality of opportunity is one of the fundamental features of justice in John Rawls’s system of justice.
Psychological justice and Person-in-the-environment

1. Society is changing rapidly in directions that are quite different from the environments we inhabited when we evolved, thus ever creating new mismatches between normal human nature and the social environment.

2. Sometimes these mismatches are sufficient to cause problems in which normal individuals fall below a fair level of access to social opportunities.

3. When society’s rules and structures are responsible for such challenges to normal individuals’ ability to access opportunity, then the individual is owed public support of psychological treatment of normal-range features aimed at bringing their psychological features more into harmony with social demands.
• In sum, the view I am proposing here is the following:
• When society’s structure and demands are primarily responsible for creating a significant mismatch between normal variations in human nature and the opportunities available to members of society, some form of redress, likely in the form of psychological help in adapting to social demands, is owed to the affected individuals.
Examples of categories that are likely sources of false positives

- Circadian rhythm disorder, shift work type
- ADHD
- Social anxiety disorder/social phobia
- Situational sexual dysfunction (with one’s partner)
- Intermittent explosive disorder, based on verbal arguments
- Substance use disorder (new 2-out-of-11-symptoms criteria)
- Major depression (after elimination of the bereavement exclusion)
Daniels’ argument against “psychological justice”

• Daniels points to how DSM has managed to provide criteria for mental disorder. He contrasts this with potential treatment of the psychologically non-disordered, which he claims leads to “moral hazard”—the inability to contain costs because anybody can then define themselves as in need of help based on subjective desires.

• Answer: The irony is that as we have seen that the DSM provides criteria that define domains warranting help even though they in fact encompass normal problems (although labeled as disorders); there is no reason to think that moral hazard is more problematic for the non-disordered than for the disordered if the target domains are carefully delineated.
Model of Reproductive Medicine
Why is availability of contraception medically necessary?

• Medical necessity of contraception often explained in terms of prevention and risk.

• Unplanned pregnancies are recognized later, thus tend not to be subject to prenatal care as early and as systematically, yielding babies with lower average birth weight and more preterm birth

• Unplanned pregnancy more often leads to abortion, which entails medical risks (Institute of Medicine 2011; Sonfield 2011; Walden 2014)).

• Thus, it is argued, lack of contraception is an unmet health need, and the United Nations’ Millenium Development Goal of improving maternal health includes satisfaction of “unmet need for contraception,” defined as the proportion of women who want to avoid or delay pregnancy but are not using contraception. (Mills et al. 2010; Westhof 2006).
But there is an alternative rationale in terms of equal opportunity

• Justice Sandra Day O’Connor in Planned Parenthood v. Casey: “the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives” (O’Connor, 1992, p. 856).
• In her dissent to the Gonzales v. Carhart decision upholding a ban on partial birth abortion, Justice Ruth Bader Ginsberg (2007) elaborated O’Connor’s idea, interspersing her narrative with quotes from the Casey decision:
Equality of opportunity as foundation for availability of contraception

• In reaffirming Roe, the Casey Court described the centrality of “the decision whether to bear . . . a child,” Eisenstadt v. Baird, 405 U. S. 438, 453 (1972), to a woman’s “dignity and autonomy,” her “personhood” and “destiny,” her “conception of . . . her place in society.” “…There was a time, not so long ago,” when women were “regarded as the center of home and family life, with attendant special responsibilities that precluded full and independent legal status under the Constitution.” Id., at 896–897 (quoting Hoyt v. Florida, 368 U. S. 57, 62 (1961)). Those views, this Court made clear in Casey, “are no longer consistent with our understanding of the family, the individual, or the Constitution.” 505 U. S., at 897. Women, it is now acknowledged, have the talent, capacity, and right “to participate equally in the economic and social life of the Nation.” Id., at 856. Their ability to realize their full potential, the Court recognized, is intimately connected to “their ability to control their reproductive lives.” Ibid. (Ginsberg, 2007)
Psychological justice

• The same kind of rationale may apply to some psychological conditions that are not medical disorders.

• Due to the demands of our society, such non-disordered conditions may deserve to be addressed by medicine as a public obligation to ensure full access to our society’s opportunities.

• This fits with the “equality of opportunity” theory of health care justice out forward by Norman Daniels.
• But where will we get a list of possible normal conditions that may warrant intervention? – in effect, a list of all the ways normal people can suffer in their social relationships?
DSM-5 V Codes/Z Codes: The New “PIE” (Person-in-Environment) System

- (But no reimbursement – yet)
- (Arguments need to focus on extending reimbursement)
No. of V Codes: DSM-IV, 23; DSM-5, 133

- Relational problems
- Problems Related to Family Upbringing
- Problems Related to Primary Support Group (e.g., disruption by separation)
- Child abuse and neglect—physical, sexual, psychological
- Spouse or Partner neglect or abuse, Physical, sexual, psychological
- Adult neglect or abuse (e.g., abuse by nonspouse/nonpartner)
- Problems of to Access or nonadherence to Medical Care
- Problems with crime or legal system (e.g., victim of crime, imprisonment)
- Housing and economic problems (e.g., homelessness, low income, discord with neighbor)
- Problems with social environment (e.g., acculturation, discrimination)
- Other psychosocial problems (e.g., religious problems; victim of torture; exposure to disaster; discord with social service provider)
- Family circumstances (e.g., high expressed emotion; sibling rivalry)
- Circumstances Personal history (e.g., military service, trauma, lifestyle)
Parity is not the end of the road for adequate mental health care

Michael Davis:

“Yesterday is no remedy for the needs of tomorrow and the evils of today should by no means be tolerated because they were worse yesterday. In order to build its own future, each generation must learn both to utilize its past and escape it.”
Conclusion

• We have an unjust psychiatric health care system.

• The future goal should be to remedy this situation and provide psychological care than ensures not just mental health (freedom from disorder), but also the psychological features needed to meet the special demands on the normal made by our society.