

## Commentary and Perspective

From time to time, the Journal receives manuscripts which can be thought of as opinion pieces, essays, or editorial comment on matters of topical interest. Such submissions will be refereed in the usual fashion and if suitable, published in this section. The Editorial Board invites Letters to the Editor or rebutting commentary with the understanding that all submissions are subject to editing.

# DSM III and Consultation–Liaison Psychiatry: Toward a Comprehensive Medical Model of the Patient<sup>1</sup>

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**Abstract:** *The descriptive and multiaxial approaches in DSM III encourage comprehensive conceptualization of the patient. The use of explicit criteria for diagnosing syndromes facilitates communication between psychiatry and general medicine. The DSM III category Psychological Factors Affecting Physical Condition should be further elaborated into (a) Psychiatric Factors Affecting Physical Condition, and (b) Physical Condition Affecting Psychiatric Disorder. In addition, the phase of the illness these factors affect should be specified, i.e., the precipitation, course, and recovery. Somatoform Disorder should not be a diagnosis of exclusion, and the diagnostic criteria should clearly specify that conversion symptoms may be superimposed on a pre-existing physical disorder. The DSM III axes are not co-*

*herent: they include diagnostic categories, statements concerning possible relationships, and factors that might affect outcome. We propose an alternative to the DSM III Axes based on the Patient Evaluation Grid (PEG), a system comprised of four axes, including Biological Dimension, Personal Dimension, Environmental Dimension, and Assessment of Interaction Among Dimensions. Developing a comprehensive diagnostic model for both medical and psychiatric patients that can be shared by all physicians may be an important function of the liaison psychiatrist.*

## Introduction

The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) (1) is a major

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advance in psychiatric nosology in two ways: first, its descriptive and phenomenological approach is well suited to communication with nonpsychiatrist physicians and, second, its innovative multiaxial approach encourages a comprehensive conceptualization of the patient. DSM III provides explicit criteria for the diagnosis of the most common syndromes in consultation–liaison psychiatry: Major Depressive Episode, Adjustment Disorder with Depressed Mood, Organic Mental Disorders (including Organic Affective Syndrome), and Substance Use Disorders. “Official” recognition of Briquet’s Syndrome as Somatization Disorder in DSM III also encourages accurate diagnosis and the possible development of treatment modalities for patients who used to be dismissed as “crocks.”

The multiaxial diagnosis attempts to demonstrate that “mental” and “physical” disorders coexist, that a patient need not be suffering from *either* a physical *or* a mental disorder.

We have encountered some difficulties, however, in using DSM III in general medical settings in the course of our clinical experience on the Psychiatric Consultation–Liaison Service at Yale-New Haven Hospital. We shall describe some of these problems and discuss possible remedies. We shall then argue for a different multiaxial approach to the patient, one that might bridge the gap between general medical and psychiatric models.

## Problems with DSM III Categories

### *Psychological Factors Affecting Physical Condition*

The DSM III category Psychological Factors Affecting Physical Condition (316.00), requires a *temporal* relationship between “psychologically meaningful environmental stimuli” and the *onset* or *exacerbation* of a physical disorder. Although these criteria are improvements over the vague “psychophysiologic or psychosomatic” disorders in past nosology, the diagnosis itself is a misnomer in that the criteria specifically exclude psychiatric conditions that might affect the course and treatment of the physical disease [2–4].

Vignette: A 54-year-old man was admitted for open-heart surgery. A psychiatric consultation was requested preoperatively because the patient had told the nurses that he wished he would not wake up from the anesthesia. Psychiatric evaluation revealed features of recurrent Major Depression with Melancholia (296.33).

If the consultant simply noted Major Depression as the diagnosis, without explicitly conveying to the surgeon that there may be increased morbidity and mortality with the surgery if the depression were not treated preoperatively [5,6], the benefits of this consultation would not be fully realized. A better way to communicate this would be to diagnose Psychiatric Factor (Major Depression) affecting proposed procedure.

As the emphasis in psychosomatic medicine has shifted from concern with a subset of medical diseases to a comprehensive approach to all patients, so should this category in DSM III that subsumes the “classical psychosomatic disorders” encompass designations of relationships between psychiatric conditions and all medical disease.

One might object to this idea on the basis that all physical and psychological factors influence each other, and that it is meaningless to make this statement in a patient’s medical record. While the first part of this assertion is indeed true, we believe that recording this relationship on the medical record becomes proper and necessary when the relationship requires focused attention because it poses a problem or a constraint in management. Thus, we recommend a revision of this category, as follows:

- a. Psychiatric Factors Affecting Physical Condition (316.00)
- b. Physical Condition Affecting Psychiatric Disorder (316.10).

Vignette: A 36-year-old woman with Chronic Generalized Anxiety Disorder (300.02) is hospitalized for dysfunctional bleeding. Uterine fibroid tumors are diagnosed and surgery is planned. The patient now develops episodes of panic.

In this case, should one change the diagnosis of Generalized Anxiety Disorder to Panic Disorder (300.01), should Panic Disorder be added to the original diagnosis, or alternatively, should one not diagnose Panic Disorder (since the planned surgery might be neurotically viewed as a “life-threatening situation”) but diagnose instead an Adjustment Disorder with Anxious Mood (309.24)? DSM III, however, implies that Adjustment Disorder with Anxious Mood should be differentiated from Anxiety Disorder (p. 301). The simplest and most useful thing to do in this case would be to make the following diagnoses:

- Axis I.
- a. Generalized Anxiety Disorder (300.02)
  - b. Physical Condition (uterine fibroma and planned surgery) Affecting Psy-

chiatric Disorder (panic and anxiety)  
(316.10)

A more appropriate name for the classical psychophysiological disorders would be: Psychological Factors Affecting Physical Condition, in Precipitation (which might be designated as 316.01).

Additional categories might be: Psychological Factors Affecting Physical Condition, in the Course and Treatment (316.02) and Psychological Factors Affecting Physical Condition, in Recovery and Convalescence (316.03). A similar elaboration may be made upon the category Physical Conditions Affecting Psychiatric Disorder.

Here, the question may be asked whether the designation of relationships such as these are really diagnoses that should fall under Axis I, or whether such relationships should be designated in another category. We will deal with this issue in a later part of this paper.

### *Somatiform Disorders*

Frequently asked questions of the liaison psychiatrist are, "Is this patient's pain psychogenic?" or, "Does this patient have pseudoseizures?" The underlying agenda of the internist or the neurologist posing these questions may be, "If the patient has a psychiatric condition like psychogenic pain, he/she does not have an organic disease, and should be transferred to a psychiatric hospital." Although DSM III diagnostic criteria are explicit in most instances, they tend to be somewhat ambiguous regarding Conversion Disorder (300.11) and Psychogenic Pain Disorder (307.80).

Given symptoms suggesting a physical disorder, the diagnosis of Conversion Disorder hinges on (a) the exclusion of a physical disorder that might explain the symptoms, and (b) a clear temporal relationship between some environmental stimulus and the onset of symptoms, and/or secondary gain derived from those symptoms. As a temporal relationship between stress and the onset of any medical disease is quite common, and secondary gain is the rule rather than the exception in most chronic illness, Conversion Disorder really becomes a diagnosis of exclusion according to DSM III.

Since the diagnosis of Hysteria (Conversion) carries much stigma and increases the likelihood of inadequate medical care for the patient, and since so many "hysterical" patients are later discovered to have had serious medical diseases that were misdiagnosed [7], we question if this diagnosis should be made without positive evidence of *specific*

*psychopathogenesis* of the "conversion," that is, resolution of the symptom through therapy or through a diagnostic intervention (e.g., temporary resolution of paralysis or aphonia through hypnosis).

DSM III does recognize that an antecedent physical disorder may predispose an individual to develop conversion symptoms of the same type (e.g., pseudoseizures in patients with epilepsy, p. 245), but the diagnostic criteria indicates that physical disorders must be ruled out. This ambiguity would be eradicated if the diagnostic criteria explicitly stated that *conversion symptoms* may be *superimposed* on a preexisting physical disorder. In fact, the most common conversion symptoms we have observed are seizure activities without EEG evidence in known epileptic patients (who have documented EEG changes in some seizures). Perhaps a distinction should be made between conversion disorder developing *de novo* and the exaggeration of or increase in symptoms of a preexisting physical disease due to psychological reasons. The latter, then, should be classified under Psychological Factors Affecting Physical Condition, discussed above.

Our problems with the Psychogenic Pain Syndrome Category are similar to those with Conversion Disorder, as the diagnostic criteria are practically identical. DSM III does state in the diagnostic criteria for Psychogenic Pain that there may, in fact, be some related organic pathology. It also states, however, that in those instances the "complaint of pain is grossly in excess of what would be expected from the physical findings." Diagnosing Psychogenic Pain in a patient with tissue damage because the complaints are "excessive" would be rendering a great disservice to the patient and the primary physician, as pain is a complex phenomenon that does not directly correlate with the extent of tissue damage [3,8].

*Vignette:* A 26-year-old woman continued to complain of severe pain at the site of a rib resection that had been performed three months earlier. Suspicious that the pain was "psychogenic" in origin, the surgical resident decided to withhold administration of the local anesthetic previously ordered by the attending physician. Frustrated and furious that her complaints were being ignored, the patient bolted from her room and required physical restraint to prevent her carrying out her threat to throw herself off the hospital roof.

We believe that all pain is "psychogenic," regardless of organic pathology, and no purpose is served by the diagnosis of Psychogenic Pain other than to attach stigma to the patient. A more appropriate diagnosis would be Chronic Pain Syndrome

in Axis III, with Psychological Factors Affecting Physical Condition or, in cases where definite psychopathogenesis can be demonstrated, Conversion Disorder-Pain, in Axis I.

### *The Depressive Syndrome*

The term Depressive Syndrome appears in some portions of DSM III (e.g., in the differential diagnosis decision tree of Mood Disturbance, p. 344) but not in the section on Affective Disorders, nor in the glossary of terms or index. An earlier draft of DSM III included diagnostic criteria for the Depressive Syndrome, which later became, with modification, the criteria for Major Depressive Episode. This is unfortunate, since the term Depressive Syndrome might have characterized what is most useful in DSM III, the syndromal approach to diagnosis [10].

Depressive Syndrome consists of all the symptoms and signs of the Major Depressive Episode without the exclusion criteria (for physical disease, schizophrenia, and so forth). The most common psychiatric syndrome diagnosed by the psychiatric consultant in a general hospital is Full or Partial Depressive Syndrome, constituting 23% of all diagnoses made at Yale-New Haven Hospital during the 1980–1981 year.

The diagnosis of nonspecific depressive syndrome leads to a differential diagnostic process by which, first, medical diseases (such as carcinoma of the tail of the pancreas, endocrinopathies, and so forth) are ruled out, followed by the ruling out of drug-related depression, then by the ruling out of environmental stressors and losses, until finally an idiopathic (or primary) Depressive Syndrome might be diagnosed. This approach, being identical to most other clinical medical diagnostic processes, is easily understood by nonpsychiatrist physicians, and facilitates collaborative evaluation and treatment.

### *Personality Disorders and Personality Traits*

Personality traits or types (3,11) are important to the primary physician and consultant psychiatrist in developing effective management plans tailor-made for the patient. This is especially so since the stresses of medical care and hospitalization often exaggerate the patient's personality traits. Although an earlier draft of the DSM III did provide for such personality traits, the final version includes only fully developed personality disorders. Given that most psychiatric consultants will be ap-

propriately reluctant to diagnose a personality disorder based on the limited data generated in the course of the typical consultation, the option of formally diagnosing salient traits would be most useful in ensuring a comprehensive formulation of the patient.

### *Diagnosis by Duration*

A characteristic feature of DSM III diagnostic criteria is that specific minimum duration of symptoms is specified for most major diagnostic entities such as Major Depression or Schizophrenia. While the duration of symptoms is an important aspect of the description of an illness, nowhere else in medicine is it used as an essential element in *diagnosing* a disease. In fact, DSM III makes it impossible, by definition, to diagnose the onset of Schizophrenia or Major Depression, let alone the subclinical prodromal manifestations of major psychiatric disorder. This is typically reconstructed retrospectively. We fully recognize that this problem exists because of our lack of knowledge concerning the pathophysiology and etiology of these conditions, that DSM III diagnostic categories are syndromes, not diseases [12]. Nonetheless, the task of eventually breaking down the syndromes into fully explainable diseases should not be hampered by confusing purely cross-sectional symptom complexes (syndromes) with the presumed courses of hypothetical diseases.

### *DSM III Axes are not Coherent*

A nonpsychiatrist colleague of ours remarked concerning the DSM III axes, "Perhaps you can find as many axes as you may want to grind." While the five axes in DSM III are important parameters to consider in predicting the outcome of Schizophrenia [13, 14], it is quite apparent that they do not represent any coherent scheme of diagnostics. Axis I represents essentially clinical syndromes, or a cross-sectional "state" diagnosis; Axis II represents developmental or personality disorders, or "trait" disturbance; Axis III represents physical disorders and conditions, both state and trait; then, Axis IV represents "severity of psychosocial stressors," an assessment of impact of recent events; and Axis V, "highest level of adaptive functioning past year," a judgment concerning psychosocial status in the recent past. This is an example of mixing apples and oranges with wine and cheese.

While few would dispute the importance of Axes

I and III, the way an Axis II diagnosis is used is somewhat different from that of Axes I and III, and Axes IV and V are not categorical diagnoses at all, but rather dimensional assessments of severity.

The multiaxial diagnosis, in simultaneously displaying psychiatric diagnosis and medical diagnosis in the same patient, dispels the either-or prejudice inherent in the psychogenic vs. physical conception of illness. However, the "classes of information" that constitute the different axes must have a coherent scheme applicable to general medicine if the approach is to facilitate the delivery of comprehensive care.

### The Patient Evaluation Grid (PEG) and an Alternative to DSM III Axes

The Patient Evaluation Grid (PEG) developed by Leigh, Feinstein, and Reiser [3,15] may be used as a basis for defining a more coherent multiaxial diagnostic approach. The PEG consists of nine squares formed by the intersection of three dimensions (biological, personal, and environmental) with three time contexts (current, recent, and background) (see Table 1). The *dimensions* represent levels of organization; the biological dimension represents the components of the individual, i.e., chemicals, tissue, and organs; the personal dimension repre-

sents the attributes of the person as a behavioral entity, including psychological and behavioral aspects; the environmental dimension represents the physical and social environment in interaction with the person. The time contexts provide information concerning the *current* state of each of the dimensions, the *recent* changes and events that might have contributed to the current state, and the long-standing *background* traits that must be considered in managing the patient.

Medical diseases (DSM Axis III) are diagnoses in the biological dimension. The chronicity of the condition may be manifest by the number of time contexts occupied by the disease. If it is found only in the current context, it is a new and acute condition. If it is found both in current, recent, and background contexts, then it is a chronic disease or disability.

Psychiatric syndromes belong in the personal dimension. The DSM III Axis I diagnoses are usually found in the current and recent contexts while Axis II diagnoses, being longstanding personality disorders, run through the background, recent, and current contexts. In fact, if a clear personality disorder seems to have emerged in the recent context in an elderly person, the probability of an organic personality syndrome (as in frontal lobe tumor) rather than a developmental personality

**Table 1.** Patient evaluation grid (PEG)

Dimensions	Contexts		
	Current (current states)	Recent (recent events and changes)	Background (culture, traits, constitution)
Biological	Symptoms Physical examination Vital signs Status of related organs Medications Disease	Age Recent bodily changes Injuries, operations Disease Drugs	Heredity Early nutrition Constitution Predisposition Early disease
Personal	Chief complaint Mental status Expectations about illness and treatment	Recent illness, occurrence of symptoms Personality change Mood, thinking, behavior Adaptation-defenses	Developmental factors Early experience Personality type Attitude to illness
Environmental	Immediate physical and inter- personal environment Supportive figure, next of kin Effect of help-seeking	Recent physical and interper- sonal environment Life changes Family, work, others Contact with ill persons Contact with doctor or hospital	Early physical environment Cultural and family environment Early relations Cultural sick role expectation

disorder increases greatly. Since the PEG considers time contexts as well as dimensions, all psychiatric syndromes can be grouped together in the personal dimension.

By using the PEG, the physician can see at once that certain environmental stressors in the recent context, environmental dimension might have been important in the precipitation or exacerbation of current medical disease (for example, acute asthmatic attack) in the current context, biological dimension. Environmental stressors constituting Axis IV in DSM III are thus found in the recent context environmental dimension in the PEG. PEG provides space for other factors that might be equally important in the precipitation of the current problem, for example, change in medication in the recent context, biological dimension, that might have caused the current delirium in the patient. DSM III provides no "axis" for such biological changes. All information found in DSM III axes are found in the PEG.

PEG is not a diagnostic scheme. Rather, it is an operational method of gathering systematic multi-axial information concerning a patient. Considering all the factors (including existing diagnoses) listed in the PEG logically leads to multi-axial operational diagnoses based on the three dimensions of the patient. In addition, since the relationships among factors across dimensions become highlighted in the PEG, a clear statement concerning such relationships can be made when appropriate. Thus, a diagnostic scheme based on the PEG would be as follows:

*New Axis*

- \*1. *Biological Dimension: Disorders of Biological Structure (anatomy) or Function (physiology or biochemistry) (DSM Axis III), constitutional traits.*
- \*2. *Personal Dimension: Affective/Cognitive/Behavioral Syndromes (DSM Axes I and II), personality traits.*
3. *Environmental Dimension: Environmental/social stressors (includes DSM Axis IV).*
- \*\*4. *Assessment of Interaction Among Dimensions:*
  - a) *Biological Factors Affecting Psychiatric Condition (specify)*

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\*We assume that some psychiatric disorders, such as the functional psychoses and the major affective syndromes, will ultimately be conceptualized on both the Biological and Personal Dimensions.

\*\*It is, of course, assumed that all factors affect all others eventually, but this assessment highlights the most important interactions that require the urgent attention of the physician.

- b) *Psychological Factors/Psychiatric Condition Affecting Physical Condition (specify)*
- c) *Environmental Factors Affecting Physical Condition (specify)*
- d) *Environmental Factors Affecting Psychiatric/Psychological Condition (specify)*
- e) *Biological Factors Affecting Environmental Condition (specify)*
- f) *Psychological Factors/Psychiatric Condition Affecting Environmental Factors (specify).*

Vignette: A 44-year-old white single male schizophrenic who was in remission for several years had a psychotic break when his work-up for lower GI bleeding revealed a colonic carcinoma. Patient required transfer to a psychiatric inpatient service for management prior to initiation of surgery and follow-up chemotherapy.

Axis I —carcinoma of the colon

Axis II —chronic schizophrenia with acute exacerbation

Axis III—being told of cancer and hospitalization

Axis IV—bleeding and diagnosis of carcinoma contributed to acute exacerbation of schizophrenia (a and d) which, in turn, affects course of treatment of the carcinoma (b).

This diagnostic scheme, based on a comprehensive evaluation of the patient, uses coherent levels of organization based on general systems theory [16] as the three "axes," and an additional axis that deals with specific interactions among specific factors in each of the three dimensions.

## Conclusions

DSM III represents a vast improvement over its predecessor in refining psychiatric syndromes and in its multi-axial comprehensive approach. It is, however, a transitional model in several respects: its axes are not coherent and are fully useful only for a subset of patients, and the diagnostic entities are at best descriptions of syndromes, that eventually will yield their place to etiologic or pathophysiological disease diagnoses. This is not to say that all psychiatric syndromes will be reducible to anatomic or biochemical diseases. Rather, the interaction between the elucidated and defined biologic condition (or vulnerability) and other personal or environmental factors may form the "disease" in the personal dimension, the subject of psychiatric diagnosis. To the extent that all medical illnesses affect behavior, this interaction among factors across dimensions must be understood for all diseases.

DSM III represents a transition within American psychiatry from a predominantly psychodynamic emphasis to a more biologic/descriptive approach. This comes at a time when medicine as a whole is in need of transition, from a superspecialized technology oriented exclusively to components of the person to an emphasis on the whole person. Through familiarity with both general medicine and psychiatry, the consultation-liaison psychiatrist may fulfill his or her function as a bridge between psychiatry and the rest of medicine by developing a comprehensive approach to the patient that can be shared by all physicians.

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