

THE REALITY OF THE *DSM* IN THE LEGAL ARENA: A PROPOSITION FOR CURTAILING UNDESIRE CONSEQUENCES OF AN IMPERFECT TOOL

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I. INTRODUCTION

The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* is a diagnostic tool privately published by the American Psychiatric Association (APA).¹ The *DSM* is highly relied upon by the medical community, from medical personnel working in psychological and psychiatric fields to those in the primary care field.² Additionally, in the legal sphere, the *DSM* is regularly relied upon by attorneys and referenced by courts in judicial proceedings.³ In fact, many state and federal statutes include definitions of mental illnesses based specifically on the diagnostic guidelines found in the *DSM* for use in both civil and criminal proceedings.⁴ Additionally, private insurance companies and several federal and state government funded programs, such as disability and benefits programs, rely on the *DSM* in determining a person's potential eligibility.⁵

¹ Although this comment refers to The American Psychiatric Association in shorthand as the APA, it should not be confused with the American Psychological Association, which is more commonly recognized by the acronym APA and has no part in the publication of the *DSM. Diagnostic and Statistical Manual*, AMERICAN PSYCHIATRIC ASSOCIATION, <http://www.psych.org/MainMenu/Research/DSMIV.aspx> (last visited Jan. 23, 2012).

² "The book is typically considered the 'bible' for any professional who makes psychiatric diagnoses in the United States and many other countries." *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)*, ALLPSYCH ONLINE, <http://allpsych.com/disorders/dsm.html> (last visited Jan. 23, 2012). "It is as important to psychiatrists as the Constitution is to the US government or the Bible is to Christians. Outside the profession, too, the *DSM* rules, serving as the authoritative text for psychologists, social workers, and other mental health workers; it is invoked by lawyers in arguing over the culpability of criminal defendants and by parents seeking school services for their children." Gary Greenberg, *Inside the Battle to Define Mental Illness*, WIRED (December 27, 2010), http://www.wired.com/magazine/2010/12/ff_dsmv/all/1.

³ See Ralph Slovenko, *The DSM in Litigation and Legislation*, 39 J. AM. ACAD. PSYCHIATRY. LAW 6 (2011).

⁴ See ARK. CODE ANN. § 5-2-305 (West 2011); MICH. COMP. LAWS ANN. § 330.1100d (West 1996); MO. ANN. STAT. § 5.285 (West 2010); NEV. REV. STAT. ANN. § 176A.045 (West 2003); N.H. REV. STAT. § 171-B:2 (West 2012).

⁵ See Ark. Code Ann. § 11-9-113 (West 2011); Cal. Welf. & Inst. Code § 5600.3 (West 2010); Conn. Gen. Stat. Ann. § 38a-488a (West 2007); 405 Ill. Comp. Stat. Ann. 80/3-3 (West 2012); Ind. Code Ann. § 27-8-10-11.2 (West 2001); Kan. Stat. Ann. § 40-2,105a (West 2009); Ky. Rev. Stat. Ann. § 304.17A-141 (West 2011); Iowa Code Ann. § 225C.51 (West 2009); Me. Rev. Stat. Ann. tit. 34-B, § 6002 (2007); N.C. Gen. Stat. Ann. §58-3-220 (West 2009); Ohio Rev. Code Ann. § 3923.281 (West 2011); Okla. Stat. Ann. tit. 36, § 6060.10 (West 2010); R.I. Gen. Laws Ann. § 27-38.2-2 (West 2001). Vt. Stat. Ann. tit. 28, § 906 (2009); W. Va. Code Ann. § 5-16-7

Since its introduction in the mid-20th century, the *DSM* has come under heavy criticism from professionals both outside and inside the psychiatric community, including more than one of the *DSM*'s past editors.⁶ Specific criticisms range from the *DSM*'s actual versus perceived reliability to the bases for its methodology and publication, both of which are kept highly secretive, to its unintended use in forensic psychiatric settings.⁷ Use of the *DSM*, both proper and improper, has been said to repeatedly lead to false diagnoses.⁸ False diagnoses can, in turn, lead to a host of problems. Given the varied usage of the *DSM*, false diagnoses could limit a mentally ill defendant's rights in criminal proceedings, lead to a sentence for lifetime confinement in a psychiatric facility for persons convicted of crimes, prevent a disabled person from receiving benefits from government programs, and lead to more prevalent insurance claims and over-medication, which is particularly problematic in times where health care costs are at an all-time high and the nation is struggling with a staggering drug shortage.

With the newest version of the manual, the *DSM-5*, currently in production and set to be released in the spring of 2013,⁹ now is an ideal time to enact guidelines and restrictions on the methods in which its content is researched and compiled, the manner in which it is published, and its function in the medical and legal realms.

This comment will discuss the various criticisms of the *DSM*'s

(West 2011).

⁶ See Stuart A. Kirk & Herb Kutchins, *The Myth of the Reliability of DSM*, 15 (1 & 2) J. MIND BEHAV., 71 (1994); Roger Collier, *DSM Revision Surrounded by Controversy*, 182(1) CAN. MED. ASSOC. J. 16 (2010); James Bradshaw, *Concerns Voiced over Secrecy Surrounding DSM-V*, THE NAT'L PSYCHOL. (May 1, 2009) <http://nationalpsychologist.com/2009/05/concerns-voiced-over-secrecy-surrounding-dsm-v/101085.html>; Larry E. Beutler & Mary L. Malik, *The Emergency of Dissatisfaction with the DSM*, in RETHINKING THE DSM: A PSYCHOLOGICAL PERSPECTIVE, 3, 4 (Larry E. Beutler & Mary L. Malik, eds., 2002).

⁷ See Kirk & Kutchins, *supra* note 6, at 72-84; Collier, *supra* note 6, at 16; Bradshaw, *supra* note 6; Beutler & Malik, *supra* note 6, at 4-6; Slovenko, *supra* note 6, at 6, 11.

⁸ See Jerome C. Wakefield, et al., *Does the DSM-IV Clinical Significance Criterion for Major Depression Reduce False Positives? Evidence From the National Comorbidity Survey Replication*, 167(3) AM. J. PSYCHIATRY 298, 298-302 (2010); Dr. Allen Frances, *Normality Is an Endangered Species: Psychiatric Fads and Overdiagnosis*, PSYCHIATRIC TIMES (July 6, 2010) <http://www.psychiatrictimes.com/dsm-5/content/article/10168/1598676>.

⁹ *About DSM-5: Timeline*, AM. PSYCHIATRIC ASSOC., <http://www.dsm5.org/about/Pages/Timeline.aspx> (last visited Jan. 23, 2012).

production and its subsequent potential dangers, particularly those related to forensic psychiatry.

It will follow with a proposal for alternative diagnostic criteria for use in legal proceedings and the creation of an advisory and regulatory board under the Department of Health and Human Services to oversee and validate the diagnostic guidelines set forth in the *DSM* (and, potentially, other medical encyclopedias for use in the medical and legal spheres.

II. BACKGROUND AND HISTORY OF THE *DSM*

Emil Kraepelin is generally credited with establishing the basis of the diagnostic classification system still used in psychiatry today as early as the late 19th century.¹⁰ This early classification system was an important innovation because classification of psychiatric disorders “[has been] seen as an organizing principle in which the complexity of the manifestations encountered in clinical psychiatry [was] reduced by arranging the phenomenon into categories according to some criterion.”¹¹ Kraepelin realized the limitations of categorizing illnesses within a single paradigm and set out to avoid building a classification system based on symptoms.¹² In the end, Kraepelin’s unsuccessful attempts at classification based on other paradigms, including pathological anatomy and etiology, largely led to precisely the same system he originally intended to avoid.¹³ Building on Kraepelin’s modest classification system, the APA published its first version of the *DSM* in 1952, which outlined then-commonly accepted psychological disorders categorically organized based on common symptoms.¹⁴

¹⁰ Beutler & Malik, *supra* note 6, at 3.

¹¹ A. M. Freedman et al., *The Range of Issues in Psychiatric Classification*, in *ISSUES IN PSYCHIATRIC CLASSIFICATION: SCIENCE, PRACTICE, AND SOCIAL POLICY* 1, 2 (Alfred M. Freedman et al. eds., 1986).

¹² See John F. Kihlstrom, *To Honor Kraepelin. . . : From Symptoms to Pathology in the Diagnosis of Mental Illness*, in *RETHINKING THE DSM: A PSYCHOLOGICAL PERSPECTIVE* 279, 284 (Larry E. Beutler & Mary L. Malik eds., 2002).

¹³ See *id.* at 285.

¹⁴ Beutler & Malik, *supra* note 6, at 4.

As a response to wide-spread criticism of its first version of the *DSM*, the APA attempted to address major issues regarding the validity and reliability of the *DSM's* classification system with its third edition of the manual.¹⁵ For the first time, while still focusing solely on symptomology as a basis for diagnosis and classification, the APA incorporated actual trial research evidence into the creation of the *DSM-III*.¹⁶ Also for the first time, the *DSM-III* contained cautionary language regarding its reliability in the treatment of mental illness, stating that, "making a *DSM-III* diagnosis represents an initial step in a comprehensive evaluation leading to the formulation of a treatment plan. Additional information about the individual being evaluated beyond that required to make a *DSM-III* diagnosis will invariably be necessary."¹⁷ It seems apparent, then, that the APA was aware of the potential danger in relying solely on the *DSM* to make a medical diagnosis.

Following the publication of the *DSM-III* and continued questions regarding its reliability, the APA attempted to focus on furthering the usage of trial studies and incorporating empirical data into the creation of the *DSM-IV*.¹⁸ Specifically, the committee focused on three stages of review: (1) systematic reviews of already published literature; (2) reanalysis of already collected but not yet published data; and (3) the collection of new data through additional field trials.¹⁹

¹⁵ See *id.*

¹⁶ Stuart A. Greenberg et al., *Unmasking Forensic Diagnosis*, 27 INT. J. LAW & PSYCHIATRY 1, 4-5 (2004).

¹⁷ COMMITTEE ON NOMENCLATURE AND STATISTICS, AM. PSYCHIAT. ASSOC., DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-III) 11 (3d ed. 1980).

¹⁸ See Robert L. Spitzer, *An Outsider-Insider's Views About Revising DSMs*, 100 J. ABNORMAL PSYCHOLOGY 294 (1991); Allen Frances et al., *The DSM-IV Classification and Psychopharmacology*, AM. C. OF NEUROPSYCHOPHARMACOLOGY (2000), available at <http://www.acnp.org/G4/GN401000082/CH081.html>.

¹⁹ Frances et al., *supra* note 18; Michael B. First et al., *DSM-IV-TR GUIDEBOOK* 29 (2004).

The release of the *DSM-5*²⁰ is currently set for Spring 2013, a date that has been pushed back multiple times due to issues conducting and reviewing new field trials.²¹ Since the *DSM-5* was announced, multiple people who played a pivotal role in the research and production of the *DSM*'s previous editions have stepped forward to voice concerns over the APA's methodology and the continued unreliability of the *DSM*.²² Even as these criticisms become more vocal, the United States legal system continues to utilize the *DSM*.

III. CRITICISM OF THE *DSM*

A. Influence of the Pharmaceutical Industry on the Creation of the *DSM-IV* and *DSM-5*

Although the most recent editions of the *DSM* purport to address issues of reliability through the integration of empirical evidence, questions have arisen regarding how well the APA actually incorporated the research data gathered through field trials.²³

Dr. Robert Spitzer—who helped develop the second edition of the manual, held a leadership position for the third edition, and served as a special advisor for the fourth edition—expressed these concerns *before* the *DSM-IV* was even released.²⁴ Dr. Spitzer acknowledged that, although the APA had reviewed previously collected data in conjunction with the organization of new field trials, it seemed as if

²⁰ See *Frequently Asked Questions*, AM. PSYCHIATRIC ASS'N, DSM-5 DEVELOPMENT, <http://www.dsm5.org/about/pages/faq.aspx#12> (last visited Jan. 15, 2012) (In recent months, the APA has chosen to drop Roman numerals in favor of Arabic numbers due to changes in technology since the *DSM*'s inception and proposed electronic dissemination once publication is complete).

²¹ Allen J. Frances, *DSM 5 Field Trials-Part 1 Missed Deadlines Have Troubling Consequences*, DSM5 IN DISTRESS, PSYCHOLOGY TODAY (Nov. 15, 2010), <http://www.psychologytoday.com/blog/dsm5-in-distress/201011/dsm-5-field-trials-part-1-missed-deadlines-have-troubling-consequences>.

²² See Collier, *supra* note 6.

²³ See Spitzer, *supra* note 18, at 294.

²⁴ *Id.*

professional consensus outweighed actual empirical data.²⁵ Essentially, he alleged that the APA was, to some extent, ignoring scientific research in favor of the theories and hypotheses of the handful of doctors involved in the *DSM*'s production.

Particularly concerning is that a majority of those involved in creating the *DSM-IV* had financial ties to organizations that continually stand to benefit indirectly from increased medical diagnoses, specifically, the pharmaceutical industry.²⁶ One research study revealed that 56% of the *DSM-IV* panel members had at least one financial link to the pharmaceutical industry, of which more than half had multiple ties.²⁷

Financial ties to the pharmaceutical industry were especially prevalent in task forces focusing on mental illnesses that are traditionally treated with drugs as opposed to cognitive or behavioral therapies.²⁸ This trend included every member of the work groups focusing on mood disorders, schizophrenia, and psychotic disorders.²⁹ It has now been reported that 70% of task force members currently working on the production of the *DSM-5* have ties to pharmaceutical companies.³⁰

There is also concern that members of the *DSM* task forces who are not already financially connected to the pharmaceutical industry may become involved with pharmaceutical companies through their work on the *DSM*.³¹ “[B]ecause their involvement with the prestigious manual makes them valuable on the lecture circuit[,]” experts working on a *DSM* task force who do not already have financial ties to the pharmaceutical industry may be enticed to create them.³² Once those ties have been created and those task force

²⁵ *Id.*

²⁶ See generally Lisa Cosgrove et al., *Financial Ties Between DSM-IV Panel Members and the Pharmaceutical Industry*, 75 *PSYCHOTHERAPY & PSYCHOSOMATICS* 154 (2006) (investigating financial ties of DSM-IV contributors to the pharmaceutical industry).

²⁷ *Id.* at 156-57.

²⁸ *Id.* at 154, 157; Collier, *supra* note 6, at 17.

²⁹ Cosgrove, *supra* note 26, at 154, 157; Collier, *supra* note 6, at 17.

³⁰ Collier, *supra* note 6, at 17.

³¹ See *id.*

³² *Id.*

members become open to receiving financial consideration from the pharmaceutical industry, their objectivity may become questionable.

Industry experts have voiced these concerns to the APA, recommending that it limit the number of people involved in the *DSM's* creation who have ties to pharmaceutical companies.³³ The APA has realized the inherent danger that pharmaceutical ties could present, having instituted a \$10,000 per year limit in consulting fees that a task force member may receive from the pharmaceutical industry.³⁴ However, the APA has not placed any limitations on the percentage of task force members who may have pharmaceutical connections.³⁵ Theoretically, the *DSM* could be produced entirely by medical personnel financially tied to the pharmaceutical industry.

It would be impossible, without first-hand knowledge, to state the extent to which these financial ties have actually influenced the classification system and symptomology of the *DSM-IV*, and how much influence they will have over the *DSM-5*. Nevertheless, it is concerning that a member of a *DSM-IV* task force expressed doubt that an improperly low weight was being given to empirical evidence.³⁶ Even more troubling is the fact that E. Jane Costello, a former member of a the *DSM-5* task group assigned to childhood disorders, submitted her resignation letter to the *DSM* production team after the *DSM-5* committee had refused to wait for results of her research and failed to conduct adequate research of its own.³⁷ She further blasted the APA by stating that the proposed revisions “seem to have little basis in new scientific findings or organized clinical or epidemiological studies.”³⁸

It is apparent that, on some level, deference has been given to task member consensus over actual, verifiable data, as evidenced by the testimony of Dr. Spitzer and Ms. Costello. One is then left to wonder how likely it is that a committee made up mostly of experts

³³ *Id.*

³⁴ *Id.*

³⁵ *See id.*

³⁶ *See Spitzer, supra* note 18.

³⁷ Greenberg, *supra* note 2.

³⁸ *Id.*

with ties to the pharmaceutical industry would be able to ignore the reality of current and future financial compensation and instead objectively focus on the empirical data necessary to create a truthful and reliable manual.

B. Concealment of the *DSM-5's* Methodology

Further heightening the scrutiny over the APA's methodology and ties to the pharmaceutical industry is the alleged secrecy with which the *DSM's* task forces conduct research and compilation of scientific data.³⁹ At the APA's 2008 annual meeting, the APA's president, Dr. Carolyn Rabinowitz, stated that the "... APA is demonstrating its commitment to "transparency" at a time of heightened public concern about pharmaceutical industry and other special-interest ties to medicine."⁴⁰

In an open letter that same year, Dr. Spitzer—who was heavily involved in the creation of the last several editions—countered that the *DSM's* process is, in fact, more secretive than ever.⁴¹ Dr. Spitzer specifically rebutted claims of "transparency" by pointing out that all task members for the *DSM-5* were required to sign confidentiality agreements.⁴²

While the APA maintains that the goal of the confidentiality agreements is simply to protect intellectual property until the *DSM-5* is published, the consequences may be devastating.⁴³ Dr. Thomas A. Widiger worked on the task force overseeing the *DSM-IV* and acknowledged the confidentiality agreements.⁴⁴ These agreements are a new part of the creation process regarding the production of the *DSM-5*, and Dr. Widiger expressed apprehension that the result of

³⁹ See Collier, *supra* note 6, at 16; Ron Grossman, *Psychiatry Manual's Secrecy Criticized*, LOS ANGELES TIMES (Dec. 29, 2008), <http://articles.latimes.com/print/2008/dec/29/nation/national-disorders29>.

⁴⁰ Robert L. Spitzer, *DSM-V: Open and Transparent?*, 43(14) PSYCHIATRIC NEWS, JULY 18, 2008, at 16, available at <http://psychiatryonline.org/newsarticle.aspx?articleid=111945>.

⁴¹ *Id.*

⁴² *Id.*

⁴³ See Greenberg, *supra* note 2.

⁴⁴ Bradshaw, *supra* note 6.

such agreements allow “only those on the task force or its working groups [to] have any knowledge of changes under consideration”⁴⁵

Not only have the confidentiality agreements sparked further suspicion of influences from the pharmaceutical industry, but questions have also arisen regarding the detrimental effect they may have on the actual scientific process.⁴⁶ Dr. Allen Frances, who served as an editor of the fourth edition of the *DSM*, has been particularly vocal in criticizing the *DSM-5*'s production, and stated that the “real problem now is the almost complete lack of openness about methods, progress, timelines, and products.”⁴⁷ In his open letter, Dr. Spitzer lamented that “this unprecedented attempt to revise *DSM* in secrecy indicates a failure to understand that revising a diagnostic manual—as a scientific process—benefits from the very exchange of information that is prohibited by the confidentiality agreement.”⁴⁸

C. Problems with the *DSM*'s Classification System as a Diagnostic Tool

Although the classification system was intended to streamline the diagnostic process, the *DSM* ultimately created a new set of problems. In particular, “for functional psychiatric disorders . . . only symptom clusters lead to classification. Information on such matters as postulated pathogenesis, etiology, drug response, heredity, and presumptive theories or mechanisms is usually ignored by *DSM*[].”⁴⁹ Because the *DSM* encourages anyone attempting to diagnose an individual to reach a conclusion based on the identification of a minimum number of symptoms within a particular set, those making diagnoses will inherently look for symptoms presented by a patient to prove a diagnosis, rather than looking at healthy behaviors or

⁴⁵ *Id.*

⁴⁶ See Spitzer, *supra* note 40.

⁴⁷ Collier, *supra* note 6, at 16.

⁴⁸ Spitzer, *supra* note 40.

⁴⁹ J. M. Davis et al., *Scientific and Pragmatic Considerations for Naming and Classifying Psychiatric Disorders*, in *ISSUES IN PSYCHIATRIC CLASSIFICATION* 92, 101 (Alfred M. Freedman et al., eds. 1986).

other factors that would tend to disprove a potential diagnosis.⁵⁰

In promoting a symptom-based classification system, the *DSM* has unintentionally created a type of circular logic: the classification system that has been created to categorize illnesses begins to influence the manner in which illnesses are recognized and thus defined.⁵¹ By relying solely on a set of symptoms that appear to fit neatly into a classification, a doctor or legal expert might miss other important factors to which the patient's symptoms could be attributed, leading to issues of misdiagnosis and overdiagnosis.⁵²

Another apparent problem with a classification system of diagnosis based on symptomology is the fact that a person may potentially exhibit few of the listed symptoms of an illness from which they are suffering, or many symptoms of an illness from which they are not.⁵³ The *DSM's* classification system works as such: if a patient manifests a minimum number of symptoms within a symptom set, the patient should be given the related diagnosis; if the patient has not exhibited enough of the symptoms within the set, they should not be given that diagnosis, regardless of the severity of the symptoms the patient *has* experienced.⁵⁴

Using depression as an example, one study explained that because all symptoms are given equal weight and only a minimum must be present, a person might be diagnosed with depression

⁵⁰ See DAVID BARONE et al., *SOCIAL COGNITIVE PSYCHOLOGY: HISTORY AND CURRENT DOMAINS* 400 (1997).

⁵¹ See *id.* at 409.

⁵² Shane J. Lopez et al., *Beyond the DSM-IV: Assumptions, Alternatives, and Alterations*, 84(3) *J. COUNSELING & DEV.* 259, 260 (2006) ("Categorically defined mental illness leads scientists and practitioners to carefully gather information to determine a person's 'goodness of fit' in a particular category. This commitment of resources to categorizing behaviors leaves few resources for the examination of behavior using other approaches. Because many professionals believe the *DSM-IV* system is a valid tool for making meaning of mental illness and health, its existence may have the effect of preempting consideration of alternative conceptualizations . . .").

⁵³ See Larry E. Beutler & Mary L. Malik, *Diagnosis and Treatment Guidelines: The Example of Depression*, in *RETHINKING THE DSM: A PSYCHOLOGICAL PERSPECTIVE* 251, 255 (Larry E. Beutler & Mary L. Malik, eds. 2002).

⁵⁴ See *id.*; Robert F. Krueger & Serena Bezdjian, *Enhancing Research and Treatment of Mental Disorders with Dimensional Concepts: Toward DSM-V and ICD-11*, 8(1) *WORLD PSYCHIATRY* 3, 3 (2009).

without having ever felt depressed.⁵⁵ Conversely, a person who experiences depressed mood may not receive a diagnosis of depression and subsequent treatment if it is his only symptom.

Compounding this issue is the instance of multiple disorders with the same or similar symptoms (particularly notable in the areas of depression and anxiety).⁵⁶ Comorbidity (the concurrent existence of more than one illness) occurs when a patient meets the baseline criteria for multiple diagnoses.⁵⁷ Because all symptoms are weighted equally, and many symptoms give rise to a multitude of diagnoses, "[t]here are several hundred statistically possible variations and combinations of symptom patterns that could, conceivably, meet diagnostic criteria."⁵⁸

This phenomenon brings into question the validity of the *DSM's* categorical classification system – is it possible that certain diagnoses overlap because they are actually etiologically related and not different illnesses?⁵⁹ Does a doctor then have to choose between treating all diagnoses reached or does he select the one he finds to be most relevant? How does a doctor know which diagnosis is most relevant when all symptoms are weighted equally? If the focus were shifted to etiology from symptomology, could diagnoses be made more accurately? What are the ultimate consequences of an unclear diagnostic system? How does this uncertainty play out in the court system, where those attempting to make a decision based on a potential diagnosis lack any additional guidance?

Many researchers have noted that the high rate of comorbidity is indicative of the possibility that various disorders may actually have a single, underlying origin, and that an alternative classification system would be "... more effective in defining impairment, symptom severity, and quality of life issues..." not currently contemplated under the *DSM*.⁶⁰

⁵⁵ Beutler & Malik, *supra* note 53.

⁵⁶ See Krueger & Bezdjian, *supra* note 54.

⁵⁷ *Id.*

⁵⁸ Beutler & Malik, *supra* note 53.

⁵⁹ See *id.*

⁶⁰ James L. Sanders, *A Distinct Language and a Historic Pendulum: The Evolution of the Diagnostic and Statistical Manual of Mental Disorders*, 25(6) ARCH. PSYCHIAT. NURS. 394,

One of the greatest limitations to this classification system is that because diagnosis is based on symptomology, a mental illness can never be diagnosed until the patient is already suffering. Perhaps in response, a startling trend has recently appeared in the *DSM*. Industry experts concerned about not being able to treat a mental illness until all of the symptoms have manifested with an interest in being able to provide preemptive treatment have led to inclusions in the *DSM* that attempt to diagnose a future disorder.⁶¹ One of the goals of the *DSM-5* has become an inclusion of a new dimension of minor or precursor forms of already diagnosable illnesses.⁶² How will diagnosing potential future disorders affect health benefits programs and disability? How would diagnosing the early stages of a mental illness affect the sentencing of a criminal defendant? Would his perceived difficulty being rehabilitated lead to a harsher sentence? Would the legal system have the objective expertise to evaluate such a situation effectively?

While the inclusion of minor or precursor forms of an illness may have been in response to the noble purpose of treating mental illnesses before their effects have become severe, the consequence will ultimately be an increase in over- and misdiagnoses and a decrease in the reliability of diagnoses. In fact, it was the proposed inclusion of such precursors of disorders that prompted Dr. Frances to speak out against the *DSM-5*, after having previously declined to join Dr. Spitzer in his public attack.⁶³

Dr. Frances explains that he blames himself, and the people he worked with, for the 40-fold increase in diagnoses of bipolar disorder and the epidemic of Autism and ADHD diagnoses since the *DSM-IV*'s release.⁶⁴ He alleges that the spike in diagnoses resulted not from a better understanding of the disorders, but rather from

399 (2011).

⁶¹ See Greenberg, *supra* note 2.

⁶² Allen Frances, *A Warning Sign on the Road to DSM-V: Beware of Its Unintended Consequences*, 26(8) *PSYCHIATRIC TIMES* (June 26, 2009), available at <http://www.psychiatrytimes.com/print/article/10168/1425378>.

⁶³ Greenberg, *supra* note 2.

⁶⁴ *Id.*

mistakes made by the committee.⁶⁵ In response to changes in the *DSM-IV*, doctors began preemptively diagnosing children with bipolar disorder in the absence of those children having ever had a manic episode.⁶⁶

Dr. Frances makes the point that this issue is particularly dangerous because doctors are now not only preemptively diagnosing patients – they are also preemptively treating them with antipsychotic drugs, the long-term effects of which are not yet known.⁶⁷ This contention is particularly alarming when considering task force members who already have ties to the pharmaceutical industry.⁶⁸ As Dr. Frances points out,

[t]he result would be a wholesale imperial medicalization of normality that will trivialize mental disorder and lead to a deluge of unneeded medication treatments – a bonanza for the pharmaceutical industry but at a huge cost to the new false-positive patients caught in the excessively wide *DSM-V* net[,] not to mention the unpredictable impact on insurability, disability, and forensics.⁶⁹

The need to monitor and validate the work of the *DSM* task force becomes even more crucial because a committee made up of members with ties to the pharmaceutical industry is now proposing changes to the *DSM* that have little to no empirical basis and would lead to a surge of medical diagnoses and pharmaceutical treatments.⁷⁰

In addition to expanding current diagnoses into what could be seen as an essentially “catch-all” dimension, the creators of the *DSM-5* also contemplated including new disorders diagnosing “so-called behavioral addictions to shopping, sex, food, videogames, the Internet, and so on.”⁷¹ Although these disorders are unlikely to lead to an increase in pharmaceutical sales, as treatments for such

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ Frances, *supra* note 62.

⁷⁰ See Spitzer, *supra* note 18, at 294-95; Greenberg, *supra* note 2.

⁷¹ Frances, *supra* note 62.

conditions consist of behavioral and cognitive therapies, the effect of the new additions classified as mental illnesses could have an immeasurable impact on the legal community. Every “mental illness” added to the *DSM* gives the legal community one more potential factor to consider in court proceedings, creates one more group of people facing potential hurdles in receiving health insurance, and adds one more dimension to benefits and disability programs.

IV. RAMIFICATIONS OF THE *DSM* OUTSIDE THE CLINIC

A. Issues Presented in Forensic Usage of the *DSM*

Psychiatric diagnoses play an important function in the legal arena; often, they can determine the outcome of a criminal or civil proceeding.⁷² The mental state of a defendant in a criminal proceeding affects “determination of competence, fitness to plead and stand trial, legal insanity, criminal culpability or responsibility, and [is viewed] in relation to criteria for compulsory psychiatric treatment.”⁷³ Additionally, “[i]n civil proceedings[,] there are often requests to attribute causality with various levels of confidence, (e.g., beyond [a] reasonable doubt, or on the balance of probabilities) and to opine on levels of impairment in social or occupational function.”⁷⁴

In *Clark v. Arizona*, the United States Supreme Court issued a cautionary statement acknowledging that certain designations in the *DSM* may suggest “that a defendant suffering from a recognized mental disease lacks cognitive, moral, volitional, or other capacity, when that may not be a sound conclusion at all.”⁷⁵ That warning notwithstanding, the Supreme Court has failed to articulate how mental disorders should be defined, and state courts have struggled to find a reliable, consistent method for determining mental illness as

⁷² See Graham W. Mellsop, et al., *Courts’ Misplaced Confidence in Psychiatric Diagnoses*, 34 INT. J. LAW PSYCHIAT. 331, 331 (2011).

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ Slovenko, *supra* note 3, at 6 (quoting *Clark v. Arizona*, 548 U.S. 735, 740 (2006)).

it relates to the legal standard of mental disease or defect.⁷⁶ As of 2011, the *DSM* had been cited in over 5,500 court opinions and over 320 legislative statutes.⁷⁷ Additionally, states have reached varying conclusions on the overall admissibility of *DSM* standards.⁷⁸

Regardless of the Supreme Court's cautionary statement, states have continued to find that the *DSM* is acceptable and admissible in criminal proceedings.⁷⁹ For instance, the New Jersey Supreme Court, while citing the United States Supreme Court's language from *Clark v. Arizona*, noted that the *DSM* does not necessarily determine a defendant's capacity, but nevertheless ruled that it was admissible as evidence and appropriate in reaching a final determination.⁸⁰ Similarly, the Supreme Court of Appeals of West Virginia held that regardless of the warning issued by the United States Supreme Court in *Clark*, the *DSM* meets the *Daubert* test for admissibility of expert evidence and that the inclusion of a disorder in the *DSM* reflects general acceptance by the psychiatric community, which may prove scientific reliability.⁸¹ Interestingly, Dr. Frances has pointed out that certain catch-all diagnoses that have created the most controversy in legal proceedings are actually included as a result of their *not* being generally accepted by the scientific and psychiatric community, a fact that seems to have been overlooked by courts electing to find the

⁷⁶ See e.g., Allen Frances & Michael B. First, *Paraphilia NOS, Nonconsent: Not Ready for the Courtroom*, 39(4) J. AM. ACAD. PSYCHIAT. LAW 555, 556 (2011); Slovenko, *supra* note 3, at 8-9.

⁷⁷ Slovenko, *supra* note 3, at 6.

⁷⁸ See generally Frances & First, *supra* note 76; Slovenko, *supra* note 3.

⁷⁹ See Slovenko, *supra* note 3, at 6.

⁸⁰ *Id.* at 7 (quoting *State v. Galloway*, 628 A.2d 735, 741 (N.J. 1993)).

⁸¹ *State v. Lockhart*, 542 S.E.2d 443, 457 (W.Va. 2000); *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579, 589-92 (1993). See Slovenko, *supra* note 3, at 6. *Daubert* abandoned general acceptance as the threshold for admissibility of scientific evidence, and instead established what has been called the "relevancy plus" standard. "In a further elaboration, the Court suggested that this 'reliability' determination 'entails a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and . . . properly can be applied to the facts in issue.' This, in turn, depends on such things as 'whether it can be (and has been) tested,' 'whether the theory or technique has been subjected to peer review and publication,' 'the known or potential rate of error,' and the 'degree of acceptance within (a relevant scientific) community.'" D.H. Kaye, *The Dynamics of Daubert: Methodology, Conclusions, and Fit in Statistical and Econometric Studies*, 87(8) VA. L. REV. 1933, 1961 (2001) (quoting *Daubert*, 590 U.S. at 590, 593-94) (emphasis added).

DSM generally admissible evidence.⁸²

Meanwhile, the consistency, or lack thereof, among courts is further compounded when applied to civil litigation.⁸³ In one case, the U.S. District Court for the District of Connecticut found that the cautionary wording in the *DSM* “appears to pertain to conclusions of law such as competence or criminal responsibility, and therefore is not applicable [in civil proceedings].”⁸⁴ The logic of the court seems to be that because the *DSM* does not specifically warn against its use in civil proceedings, its use in such situations is perfectly acceptable, regardless of widespread questions of its reliability. As of 2012, this case has since been cited in 29 other court proceedings.⁸⁵

The *DSM* understandably must have seemed like a breakthrough to the legal community upon its publication—a tool that would help clarify medical phenomena relevant to legal proceedings, but not of common knowledge to the legal community. Unfortunately, the *DSM* was neither intended nor designed for such a use.⁸⁶ The APA states that the *DSM* “has been designed for use across clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care), with community populations.”⁸⁷ Additionally, the APA has stated that one of the four principles of the *DSM-5* revision process is to create “above all a manual to be used by clinicians”⁸⁸ Noticeably lacking from the description of the *DSM* is any intended use as a forensic tool.⁸⁹ In fact, with the publication of *DSM-IV-TR*, a mildly revised version of the *DSM-IV*, the APA

⁸² See Frances & First, *supra* note 76, at 557. As of the most recent edition, 46 such catch-all categories of diagnoses are listed in the *DSM*. *Id.*

⁸³ See Slovenko, *supra* note 3, at 7-8.

⁸⁴ *Discepolo v. Gorgone*, 399 F. Supp. 2d 123, 127 n.2 (D. Conn. 2005).

⁸⁵ Citing References – *Discepolo v. Gorgone*, WESTLAWNEXT, <http://1.next.westlaw.com> (search for “*Discepolo v. Gorgone*,” then follow “*Discepolo v. Gorgone*” hyperlink; then follow “Citing References” hyperlink).

⁸⁶ See DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, AM. PSYCHIATRIC ASS’N, <http://www.psychiatry.org/practice/dsm> (last visited Nov. 1, 2012).

⁸⁷ *Id.*

⁸⁸ Kenneth Kendler et al., *Guidelines for Making Changes to DSM-V*, AM. PSYCHIATRIC ASS’N DSM-5 DEV., http://www.dsm5.org/ProgressReports/Documents/Guidelines-for-Making-Changes-to-DSM_1.pdf (last revised Oct. 21, 2009).

⁸⁹ See DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, *supra* note 84a.

included a caveat cautioning against the dangers inherent in using it as a legal tool:

[W]hen used for forensic purposes, there are significant risks that diagnostic information will be misused or misunderstood. These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis . . . In determining whether an individual meets a specified legal standard . . . additional information is usually required beyond that contained in the *DSM-IV* diagnosis.⁹⁰

In one of the most pertinent examples of the potential dangers inherent in misunderstanding and misapplication of the *DSM*, linguistic changes to the *DSM-IV* sparked recent confusion in the court system with regard to proceedings in rape cases.⁹¹ Dr. Frances, who helped revise the particular passage in question, admits that “[t]he wording of the *DSM-IV* Paraphilia section was written long before the issue of [sexually violent predator] commitment arose . . .” and that the committee was “not aware of the consequential problems that would later arise from the fact that the section lacked the clarity and precision necessary for legal purposes.”⁹² Based on his personal experience editing the last several versions of the *DSM*, Dr. Frances has declared that one of the inherent dangers of forensic use of the *DSM* is that the committee appointed by the APA

do[es] not understand that the *DSM* is read very differently by lawyers. . . [, and e]ven when the *DSM* criteria sets and text are written with a consistency that is sufficient for clinical, research, and educational purposes, the wording does not always stand up well to the technical rigor of precise legal dissection. By training and inclination, lawyers parse every phrase for meanings never foreseen by

⁹⁰ Greenberg, *supra* note 16 at 6 (quoting AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS TEXT REVISION (4th ed. 2000)).

⁹¹ See Allen Frances, *The Forensic Risks of DSM-V and How to Avoid Them*, 38 J. AM. ACAD. PSYCHIAT. LAW 11, 12 (2010); Slovenko, *supra* note 2, at 7.

⁹² See Frances & First, *supra* note 76 at 556. Dr. Frances’s mention of sexually violent predator commitment refers to legislation enacted by twenty states and the federal government “allowing for the continued incarceration of a particularly dangerous offender, but only if he could be demonstrated to have a mental disorder that was responsible for predisposing him to be at continuing risk for recidivism[.]” in response to public outcry over an average seven-year sentence for rape. *Id.* at 555.

those writing primarily for a psychiatric audience.⁹³

Since publication of the *DSM-IV*, forensic evaluators have repeatedly attempted to use the diagnosis of Paraphilia Not-Otherwise-Specified, essentially as a catch-all diagnosis for deviant sexual behavior not otherwise specifically defined to justify lifetime commitment to a psychiatric hospital of rapists based simply on the fact that their behavioral pattern was supposedly listed as a mental disorder.⁹⁴ In reality, the *DSM* committee intentionally chose to omit any portion referring to the commission of rape as a symptom of mental illness.⁹⁵ An editing mistake substituting the word “or” for “and” led the legal community to begin pursuing lifetime commitment for criminals who otherwise would have enjoyed a constitutional right to release at the conclusion of their sentences.⁹⁶

Although misuse of the *DSM* to support a questionably unconstitutional practice is certainly troubling, even more concerning is the usage of the *DSM* in capital proceedings. In such cases, misuse or misunderstanding of an improperly researched and published diagnostic criterion could determine whether a defendant is competent to stand trial, eligible for capital punishment, and competent at the time of execution for the death sentence to be effected.⁹⁷ Even some states that do not specifically reference the *DSM* in their capital procedure legislation have nonetheless adopted wording almost identical to that included in the *DSM*.⁹⁸ With

⁹³ Frances, *supra* note 91, at 11.

⁹⁴ See Frances, *supra* note 62; Frances & First, *supra* note 76, at 556-57. “In DSM-IV and in DSM-IV-TR, the Paraphilia NOS category (diagnostic code 302.9) states: ‘This category is included for coding Paraphilias that do not meet the criteria for any of the specific categories. Examples include, but are not limited to: telephone scatologia (obscene phone calls), necrophilia (corpses), partialism (exclusive focus on parts of the body), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), and urophilia (urine).’” Martin P. Kafka, *The DSM Diagnostic Criteria for Paraphilia Not Otherwise Specified*, 39(2) ARCH. SEX BEHAV. 373, 374 (2010) (citation omitted).

⁹⁵ See Frances & First, *supra* note 92, at 557.

⁹⁶ *Id.* at 555, 557.

⁹⁷ See Timothy S. Hall, *Legal Fictions and Moral Reasoning: Capital Punishment and the Mentally Retarded Defendant After Penry v. Johnson*, 35 AKRON L. REV. 327, 335-36 (2004); Ford v. Wainwright, 477 U.S. 399, 410 (1986) (holding that under the Eighth Amendment to the United States Constitution a mentally ill person cannot be executed).

⁹⁸ See Hall, *supra* note 97, at 335.

questions arising regarding the validity of the *DSM* from its own contributors and a lack of consensus among courts on how, or even whether, its criteria should be applied, the *DSM* should not constitute the underlying basis for assessing whether a person convicted of a capital crime should live or die.

B. Employment of the *DSM* in Other Civil Procedures and Legislation

In addition to criminal and civil court proceedings, the federal government and many states utilize the diagnostic criteria in the *DSM* in determining eligibility for governmental or healthcare benefits, which may be contingent on whether or not a person meets a specific definition of mental illness.⁹⁹ For example, in a Tennessee Court of Appeals case for negligent infliction of emotional distress, the court held that the amount the jury awarded to the plaintiff was unreasonable because the plaintiff did not meet the diagnostic criteria as specified in the *DSM*, and therefore his injury could not be considered a serious or severe impairment.¹⁰⁰ Moreover, the federal government and multiple states specifically reference the *DSM* in guidelines set forth under their parity laws and insurance regulations, often using the *DSM* as a determinant of a person's eligibility for benefits programs.¹⁰¹

Courts have also utilized the *DSM's* diagnostic criteria in

⁹⁹ See Slovenko, *supra* note 3, at 8-9. See also EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities, EEOC (Mar. 25, 1997), available at <http://www.eeoc.gov/policy/docs/psych.html>; *State Laws Mandating or Regulating Mental Health Benefits*, NAT'L CONFERENCE OF STATE LEGISLATURES (Dec. 2011), <http://www.ncsl.org/issues-research/health/mental-health-benefits-state-laws-mandating-or-re.aspx> [hereinafter NCSL].

¹⁰⁰ See *Riley v. Orr*, No. M2009-01215-COA-R3-CV, 2010 WL 2350475, at *10 (Tenn. Ct. App. June 11, 2010).

¹⁰¹ See NCSL, *supra* note 99. The Emergency Economic Stabilization Act was enacted by Congress on Oct. 3, 2008 and included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. This federal parity provision does not apply to group plans preempted by ERISA statutes and typically does not affect federally funded programs. However, it requires non-exempt insurance plans that offer mental health coverage to provide the same financial and treatment coverage provided for physical illnesses. Some states have enacted stricter parity laws. See *id.*; Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, 122 Stat. 3765 (2008).

workers' compensation hearings to varying outcomes.¹⁰² For example, it has been established in Louisiana that the third prong for recovery of benefits for a mental injury stemming from a physical injury is that "the diagnosis must meet the most current criteria established by the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*."¹⁰³ Conversely, the Wyoming Supreme Court has held that a person is *not* eligible for benefits under a workers' compensation program *because* the affliction appears in the *DSM*, by virtue of which it could not be considered a physical injury.¹⁰⁴ Meanwhile, a New Mexico Court of Appeals decided that because the wording defining a particular mental illness in a workers' compensation statute mirrored that in the *DSM*, that use of the *DSM* was acceptable to further establish (or rather, disprove) the plaintiff's assertion that he was eligible for compensation.¹⁰⁵ Given the concerns expressed by members of the *DSM*'s own former editors and contributors in regards to its scientific validity and reliability, should it be the basis for determining whether a person is eligible to receive benefits?

V. PROPOSED SOLUTION & CONCLUSION

The most critical underlying problem with the *DSM* appears to be the method in which it is produced. Specifically, rampant ties between the APA's *DSM* task force and the pharmaceutical industry could inevitably lead to inclusion of or emphasis on new diagnostic criteria specifically likely to increase sales of pharmaceuticals.

Moreover, emphasis seems to be placed on the "expert opinions" of these contributors rather than any outside empirical research, and the *DSM* has become closed off from a court of public opinion through its incorporation of confidentiality agreements. While it is understood that the *DSM* is, essentially, a private publication by a

¹⁰² See Slovenko, *supra* note 2, at 8 (referencing *Saunderlin v. E.I. Du Pont Co.*, 508 A.2d 1095 (N.J. 1986) (holding that the *DSM* provides a framework for "demonstrable objective medical evidence.")).

¹⁰³ *Charles v. S. Cent. Indus.*, 683 So.2d 706, 709 (La. 1996).

¹⁰⁴ See *Wheeler v. State*, 245 P.3d 811, 817 (Wyo. 2010).

¹⁰⁵ See *Romero v. City of Santa Fe*, 134 P.3d 131, 135 (N.M. App. 2006).

private organization, it must be recognized that it is widely relied upon and considered a psychiatric encyclopedia in the medical and legal communities. In practice, the *DSM* is not typically viewed as a private publication, but rather as a scientific tool. Moreover, many of those who rely on the *DSM* may consider it to have a sound basis in science and fact; however, they may be unaware of criticisms regarding its publication.

If a medical diagnostic publication is to exist in this capacity, there should be federal regulations setting forth acceptable practices in its formation and methodology. Such guidelines should also require disclosures where the publication or publishing board fails to meet these criteria. A reasonable limitation should be set in place establishing what percentage of contributors have ties to companies that could potentially benefit from collusion during the editing process. While the APA maintains that it has established that not one person may receive more than \$10,000 a year, there should be a limit on *what percentage of contributors* can receive pharmaceutical payouts or potentially benefit from the pharmaceutical industry while working on the task force both prior to and post its publication.

Federal guidelines should also establish a reasonable minimum amount of empirical evidence required to edit an existing diagnostic criterion or to add a new diagnosis. Rather than allowing the APA to defer to the influence of contributor's opinions simply because of lack of funding or time or any other reasons alleged, a publication that is intended to be used by the medical community as a diagnostic tool should be based on actual scientific evidence. As such, a guideline for the threshold amount of empirical or historical evidence should be required for the inclusion of each and every diagnosis. While the threshold amount of evidence may vary depending on how relatively new or established a particular diagnosis is, there should be enough evidence that medical or legal personnel can feel confident in applying the *DSM*.

As for the *DSM's* function in the legal system, the APA's current approach is to attempt to protect themselves from liability by including a caveat warning against such uses. Given the particular difficulties in understanding and applying mental illness, the *DSM's* continued use in the legal community is reasonably foreseeable. Moreover, the APA is or should be fully aware of its use, regardless

of their warning language. Instead of trying to shield themselves from liability for unintended use, the APA and anyone else producing a medical diagnostic tool should work to create a manual that court proceedings accept as scientifically verifiable.

Currently, the *DSM* affects eligibility for insurance and disability benefits, culpability in civil and criminal proceedings, injury in civil proceedings and worker's compensation claims, competency of a defendant to stand trial, the possibility that a defendant will be forced into a lifetime of psychiatric commitment in addition to serving his sentence, and in the most extreme cases, the difference between life and death for a person convicted of a capital crime. The APA cannot simply ignore its role in these circumstances by issuing a cautionary statement. Instead, they must work to create a scientifically valid manual.

These goals could be accomplished by establishing a regulatory and research board under the Department of Health and Human Services. This board would work with the medical and legal industries to research what appropriate guidelines should be instituted in the publication of medical diagnostic tools; they would then provide those recommendations to the legislature. Diagnostic tools that fail to meet the recommended guidelines would still be publishable, but researchers would be required to disclose that the tools do not meet the recommended guidelines.

In addition, the board could work with the APA and other medical groups in the production and maintenance of medical encyclopedias to help ensure that they are scientifically sound and appropriately edited. The board would ideally comprise both legal and medical scholars. They could then work with medical groups such as the APA in conducting on-going research on current and possible future effects of specific criteria in the *DSM* as it relates to the medical, legal, and legislative communities. By establishing a board focused on continually gathering empirical scientific data, time and funding constraints cited by the APA could be alleviated.

Finally, this board could also function to work with federal and state legislative committees. In doing so, this board could help craft statutes that would work in tandem with the *DSM*, both in the way that they are worded and in the manner through which they incorporate the *DSM's* diagnostic guidelines to create cohesion

between courts and to reduce legal ambiguity.

The psychiatric community likely cannot create a perfect diagnostic tool any time in the near future, simply due to a general lack of understanding of the true causes of mental illness. Regardless of this unquestionable hurdle, strides must be taken for the benefit of the general public to create a diagnostic tool that functions with the highest degree of reliability. It is uncontroverted that the *DSM* contributes extensively to the diagnoses of mental illnesses every day. These diagnoses ultimately affect a person's medical treatment and health. Additionally, these diagnoses contribute to legal standards and strategies, and they may be deciding factors in a person's legal rights and ultimate future. Above all, a moral duty is owed to society to ensure that the diagnostic tools being used by the medical and legal communities are as scientifically sound and reliable as technologically possible.