The Diagnostic and Statistical Manual of Mental Disorders (DSM):
An Overview

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**Chapter 3–8**

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3–8:01 Introduction

Using the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition* [hereinafter DSM–IV] can introduce problems in family law—and other—cases. Consider the following scenarios: a divorcing mother alleges that the father has “mood swings” that affect his conduct and judgment with their children; a plaintiff claims that she is experiencing anxieties and sleep disturbances after alleged incidents of sexual harassment; or a patient expresses apparent delusional beliefs when discussing his involvement in an alleged criminal activity. If a mental health professional was treating any of these cases in her office, a DSM–IV diagnosis might help the professional conceptualize the case or, at least, document a mental disorder for insurance reimbursement. However, the DSM–IV warns that using DSM–IV categories, criteria, and textual descriptions for forensic (or legal) purposes poses significant risks “because of the imperfect fit between the questions of ultimate concern to the law and the information contained in clinical diagnosis.”

Also, the DSM–IV notes, “(T)he clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency.”

In family law cases, the “best interest of the child” criterion looks largely to parenting capacities and the parenting relationship, not to diagnostic classifications of mental disorders.

Despite the caveats for the use of DSM–IV in court, diagnostic classifications can be useful tools for the mental health professional’s assessment of a legal contention. Those classifications also may provide the mental health professional with hypotheses about a legal claim that could be helpful in resolving the question at issue in a court case. For example, a parent disputing custody and diagnosed with a Narcissistic Personality Disorder could be so self-centered and exploitative in relationships that she would not have the ability to empathize adequately with her child’s needs or to meet those needs. While these hypotheses arising from a DSM–IV diagnosis might help guide the mental health professional’s inquiries, the professional still must connect those hypotheses to actual parenting behaviors.

Nowhere in the Texas Family Code or in case law is “best interest of the child” equated to a DSM–IV diagnoses, no matter how severe the diagnosis.

While using the DSM–IV classification system might be useful for many mental health professionals in their offices, is the DSM–IV reliable enough to be admitted into evidence in court? As noted in other chapters in this manual, the line of cases highlighted by *Daubert v. Merrell Dow Pharmaceuticals*, 509 U.S. 579 (1993), *E.I. duPont de Nemours and Co. v. Robinson*, 923 S.W.2d 549, 556 (Tex. 1995), and *Gammill v. Jack Williams Chevrolet*, 972 S.W.2d 713 (Tex. 1998) emphasize that scientific testimony must be relevant and reliable to be admitted under Rule 702 of the Texas Rules of Evidence. This chapter will address the use and development of the DSM–IV, the structure of a DSM–IV diagnosis, and the reliability issues, both pro and con, that arise from that ubiquitous classification system of mental disorders.

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2 DSM–IV xxiii.

3 DSM–IV xxvii.


5 *See* discussion of Thomas Grisso model of organizing evaluation data in § 3–80:05(3) of this Manual.

3–8:02  What is the DSM?

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a diagnostic system, developed under the direction of the American Psychiatric Association, that classifies mental disorders. It is the primary diagnostic system for mental disorders used in the United States; one author—a DSM–IV Task Force member—asserted that more than 500,000 mental health professionals use the DSM–IV in their practices.7

Since its inception, DSM has been through five editions. DSM–IV, the current edition, was published in 1994. Previous DSM editions included DSM–I (published in 1952), DSM–II (published in 1987), DSM–III (published in 1980), and DSM–III–R (published in 1987). Each DSM edition was expanded from the previous edition, with more diagnostic categories and changed or new criteria for various disorders with each revision. DSM–III marked a significant change from the previous DSMs. DSM–I and DSM–II were not empirically based, relying mainly on a consensus reached by the small number of senior academic psychiatrists who drafted them.8 DSM–III grew out of psychiatric research in the 1970s that identified diagnostic criteria for certain mental disorders. Consequently, DSM–III developed explicit criteria to describe Mental Disorders.9 In addition, DSM–III introduced a new method for reporting mental disorders, requiring the mental health professional to classify the patient’s disorder on five different dimensions, or axes.10 The development of DSM–IV involved a substantially larger and more heterogeneous group of mental health professionals—including more women, more members of racial and ethnic minority groups, and more non-psychiatrists—than were used to develop previous DSM editions.11 In addition, DSM–IV is more empirically based than its predecessors.

Since 1992, mental health professionals outside the United States have used chapter 5 of the 10th edition of the International Classification of Diseases 12 [hereinafter ICD–10] as a basis for diagnosing mental disorders. The previous ICD edition, ICD–9, was developed and modified prior to the 1980 publication of DSM–III, and, consequently, had not been empirically oriented nor informed by the surge of research in psychopathology that followed DSM–III’s publication. Work on ICD–10 began in 1983; ICD–10 was formally approved by the World Health Organization in 1990. But, as with the Mental Disorder definitions in DSM–III and DSM–III–R, ICD–10 definitions were largely

7 Peter E. Nathan, In the Final Analysis, It’s the Data that Counts, 4 CLIN. PSYCHOL.: SC. & PRACT. 282 (1997).


12 WORLD HEALTH ORGANIZATION, INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH ED. (1992).

Chapter 3–8 p. 3
the product of expert consensus\textsuperscript{13} that were also informed some by international field trials\textsuperscript{14} and knowledge of the psychopathology research. While previous editions of the ICD and DSM differed substantially, efforts were made in the mid-1980s to harmonize DSM–IV with ICD–10. Simultaneous work on DSM–IV and ICD–10 allowed for much mutual influence and increased the convergence of the two systems.\textsuperscript{15} ICD–10 and DSM–IV are much more similar to each other than ICD–9CM was to DSM–III and DSM–III–R.\textsuperscript{16} While sometimes in different classes, most of the same similarly described diagnoses are represented in both ICD–10 and DSM–IV.\textsuperscript{17}

Although DSM–IV and chapter 5 of ICD–10, appear to be compatible in their classifications of Mental Disorders,\textsuperscript{18} the formats of the two systems differ. ICD–10 provides brief descriptions of the disorders instead of the more lengthy reviews in DSM–IV. Rather than explicit diagnostic criteria with inclusion and exclusion criteria and “rules” for diagnosis as in DSM–IV, the ICD–10 clinical version provides “diagnostic guidelines,” essentially in a narrative style with repeated usage of qualifiers such as “normally,” “usually,” and “should,” rather than “require” as in DSM–IV.\textsuperscript{19}

\textbf{3–8:03 How is DSM–IV Used?}

DSM–IV is used for at least three primary purposes. First, DSM–IV is used to communicate among mental health clinicians, researchers, and educators about diagnostic issues related to mental disorders. In addition, DSM–IV is used to plan mental health treatment of patients with mental disorders and to anticipate treatment outcomes.\textsuperscript{20} Also, given its wide acceptance, DSM–IV diagnoses are used by the health care/insurance industry to reimburse financially treatment by mental health professionals.

While DSM–IV diagnoses generally require meeting certain criteria, DSM–IV emphasizes that clinical judgment is necessary to apply the diagnostic criteria for mental disorders. The DSM–IV criteria are meant to serve as guidelines to be informed by clinical judgment. The criteria are not


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meant to be used in cookbook fashion or to be applied mechanically by untrained individuals. Clinical judgment is necessary to apply the diagnostic criteria because of the two most important issues that arise in using the DSM–IV: 1) even within a disorder, patients may differ considerably, and 2) the boundaries between disorders are often fuzzy, that is, many patients manifest combinations of symptoms that “fall through the diagnostic cracks” and cannot be comfortably forced into any of the DSM–IV categories.

The DSM–IV does not define “clinical judgment.” DSM–IV notes that “the proper use of these criteria requires specialized clinical training that provides both a body of knowledge and clinical skills.” Further, DSM–IV notes that, “the diagnostic categories, criteria, and textual descriptions are meant to be employed by individuals with appropriate clinical training and experience in diagnosis. For example, the exercise of clinical judgment may justify giving a certain diagnosis to a patient even though that patient’s clinical presentation falls just short of meeting the full criteria for the diagnosis as long as the symptoms that are present are persistent and severe. The authors of the DSM–IV Guidebook try to explain the use of clinical judgment in the use of the DSM–IV in a way that could raise questions, depending on the experience of the diagnostician, about the reliability of the DSM–IV’s use in court:

If clinicians do not exercise clinical judgment, they will be slavishly following a system with admittedly and necessarily arbitrary boundaries. On the other hand, the excessively flexible and idiosyncratic application of the system (or ignorance of it) substantially reduces its utility as a common language for communication among clinicians and across the research-clinical interface.

Given the interaction between clinical judgment and application of diagnostic criteria, one might understand better DSM–IV’s caveat that “when the DSM–IV categories, criteria, and textual descriptions are employed for forensic (or legal) purposes, there are significant risks that diagnostic information will be misused or misunderstood.”

Finally, for treatment planning purposes, assigning a DSM–IV diagnosis is only the first step in a comprehensive evaluation. For example, a patient may present herself to a mental health professional with symptoms that fit the criteria for a major depressive disorder and produce valid test

21 DSM–IV xxiii.

22 ALLEN FRANCES, MICHAEL B. FIRST & HAROLD A. PINCUS, DSM–IV GUIDEBOOK 19 (1995); See also discussion in § 9:10(3)(d) of this chapter regarding categorical v. dimensional v. prototypical approaches to classification.

23 DSM–IV xxvii.

24 DSM–IV xxiii.

25 DSM–IV xxiii.


27 DSM–IV xxiii.

28 DSM–IV xxv.

Chapter 3–8 p. 5
profiles that reflect significant depression. With a bit of history from the patient, the professional could diagnose the patient with a major depressive disorder. However, further history taking and an understanding of the symptoms’ meanings to the patient or an assessment of possible biological contributions to the patient’s condition would be necessary to devise an effective treatment plan for the patient.

In sum, a DSM–IV diagnosis does not, by itself, define a comprehensive psychiatric/psychological evaluation, nor is a DSM–IV diagnosis a legal conclusion. These caveats make it incumbent on the mental health professional, if she uses the DSM–IV to inform her opinion, to articulate how the DSM–IV diagnosis relates to the issue about which that professional is giving an expert opinion.29

3–8:04 How was DSM–IV Developed?

DSM–IV was developed by a large group of mental health professionals, mostly psychiatrists. The group was headed by The Task Force on DSM–IV and 13 work groups which represented the disorders that were considered for inclusion in DSM–IV. The Task Force on DSM–IV and its work groups conducted a three-stage empirical process that included 1) comprehensive and systematic reviews of the published literature, 2) reanalyses of already-collected data sets, and 3) extensive issue-focused field trials.30 The DSM–IV Sourcebook, published in five volumes, provides a comprehensive reference record of the clinical and research support for the various decisions reached by the Work Groups and the Task Force.31

The threshold for change in DSM–IV was set at a much higher level than was the case for either DSM–III or DSM–III–R. Overall, DSM–IV is a relatively conservative document that made changes from DSM–III–R only when necessary to respond to new (empirical) findings, to increase

29 See Gammill v. Jack Williams Chevrolet 972 S.W.2d 713, 726 (Tex. 1998) for the proposition that “a court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.”; See also Tope v. America West Airlines 935 S.W.2d 908, 918 (Tex.App.-El Paso 1996, no writ) where the social worker’s testimony was excluded because her opinion relied solely on a DSM–IV diagnosis which was arrived at subjectively and was based solely on asking the plaintiff about his symptoms. The social worker offered no objective, or other, evidence, by testing or even interview notes, to support her opinion.

30 “When a literature review confirmed a gap on a pressing diagnostic question, one or both of the succeeding two stages of the empirical process were implemented. The work group could analyze existing patient data sets potentially capable of answering the unresolved diagnostic questions. Or it could design and carry out a field trial to generate new patient data sets for analysis. In practice, both options were used by virtually every work group. Forty analyses of existing patient data sets were supported by the MacArthur Foundation; 12 large-scale field trials at more than 70 sites, involving more than 7000 patients, were funded by the National Institute of Mental Health, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism.” Peter E. Nathan, The DSM–IV and its Antecedents: Enhancing Syndromal Diagnosis, in MAKING DIAGNOSIS MEANINGFUL 3, 18 (J.W. Barron ed., 1998); see also DSM–IV xviii–xix.

“The field trials allowed the DSM–IV Work Groups to compare alternative options and to study the possible impact of suggested changes. Field trials compared DSM–III, DSM–III–R, ICD–10, and proposed DSM–IV criteria sets in 5–10 different sites per field trial, with approximately 100 subjects at each site. Diverse sites, with representative groups of subjects from a range of sociocultural and ethnic backgrounds, were selected to ensure generalizability of field-trial results and to test some of the most difficult questions in differential diagnosis.” DSM–IV xix.

31 DSM–IV xx.
3–8:05 How is a DSM–IV Disorder Described?

Each DSM–IV disorder is described under most of the following categories:33

• Diagnostic features;
• Subtypes and/or Specifiers of severity, course, or stage of disorder;
• Recording Procedures;
• Associated Features and Disorders;
• Specific Culture, Age, and Gender Factors;
• Prevalence, that is, available data on point and lifetime prevalence, incidence, and lifetime risk for different settings (e.g. community, primary care, outpatient mental health clinics, and inpatient psychiatric settings) when this information is known;
• Course, that is, the typical pattern and development of the disorder, including typical age at onset, and length and progression of the disorder;
• Familial Pattern of the disorder;
• Differential Diagnosis, that is, differentiating the disorder from other disorders with similar characteristics.

3–8:06 How is a Full DSM–IV Diagnosis Structured?

A full DSM—IV diagnosis is arranged on five axes, each of which refers to a different domain of information about the patient. The purposes of a multiaxial diagnosis are to organize and communicate clinical information, to capture the complexity of clinical situations, and to describe the symptom variety in persons presenting with the same diagnosis.34 Again, remember that the diagnoses were not developed for legal purposes.35

A full DSM—IV diagnosis involves an assessment in several areas, each defined by one of five axes. While the full diagnosis is intended to provide an overall context for the person’s mental disorders, the mental disorders themselves are classified on the first two axes. The five axes are:

• AXIS I: Clinical disorders and/or other conditions that may be a focus of clinical attention, generally disorders that are more transient and episodic—depressions, anxiety conditions, psychotic conditions, and adjustment disorders are among the Axis I disorders. All disorders or conditions except for Axis II disorders are listed on Axis I.36

• AXIS II: Personality Disorders and/or Mental Retardation—
A Personality Disorder is a long-term pattern of characteristics that organizes a person’s emotional and perceptual experiences and interpretations of others, self, and events in a manner that

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33 DSM–IV 8-9.

34 DSM–IV 25.

35 DSM–IV xxiii, xxvii.

36 DSM–IV 25.
is pervasive and inflexible across a broad range of personal and social situations.\textsuperscript{37}

\textquote{The essential feature of Mental Retardation is significantly subaverage general intellectual functioning (below an Intelligence Quotient of about 70) that is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety."} \textquote{Adaptive functioning refers to how effectively individuals cope with common life demands and how well they meet the standards of personal independence expected of someone in their particular age group, sociocultural background, and community setting.}

\textbullet{} **AXIS III: General Medical Conditions**—the presence of physical/medical conditions that are potentially relevant to the understanding or management of the individual’s mental disorder.\textsuperscript{38}

\textbullet{} **AXIS IV: Psychosocial and Environmental Problems**—such problems that may affect the diagnosis, treatment, and prognosis of mental disorders (i.e. Axes I and II). When making an Axis IV entry, the mental health professional should identify the relevant categories and the specific problems. Such problems include:\textsuperscript{40}

- Problems with primary support group—e.g. separation/divorce, abuse, parental overprotection, death of a family member, inadequate discipline.
- Problems related to the social environment—e.g. death or loss of a friend, inadequate social support, living alone, adjustment to a life-cycle transition (such as retirement).
- Educational problems—e.g. illiteracy, academic problems, discord with teachers or classmates, inadequate school environment.
- Occupational problems—e.g. unemployment, threat of job loss, stressful work schedule or difficult work conditions, job dissatisfaction.
- Housing problems—e.g. homelessness, discord with neighbors or landlord, inadequate housing.
- Economic problems—e.g. extreme poverty, inadequate finances.
- Problems with access to health care services—e.g. inadequate health care services, transportation to health care facilities unavailable, inadequate health insurance.
- Problems related to interaction with the legal system/crime—e.g. arrest, incarceration, litigation, victim of crime.
- Other psychosocial and environmental problems—e.g. exposure to disasters; war; other hostilities; discord with nonfamily caregivers such as counselor, social worker, or physician; unavailability of social service agencies.

\textbullet{} **AXIS V: Global Assessment of Functioning**—a numerical rating of the individual’s overall level of functioning based on the clinician’s judgment. The rating is from 100 (i.e. superior functioning in a wide range of activities) to 10 (i.e. persistent danger of severely hurting self or others. Some other number point examples: 70=some mild symptoms; 60=moderate symptoms; 50=serious symptoms; 40=some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking or mood; 30=behavior considerably influenced by delusions or hallucinations OR serious impairment in

\textsuperscript{37} DSM–IV 629.

\textsuperscript{38} DSM–IV 39-40.

\textsuperscript{39} DSM–IV 27.

\textsuperscript{40} DSM–IV 29-30.
communication or thinking; 20=some danger of hurting self or others.\footnote{DSM–IV 30–32.}

Following is an example of a full DSM—IV multiaxial diagnosis:

<table>
<thead>
<tr>
<th>Axis</th>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>Axis I</td>
<td>296.23</td>
<td>Major Depressive Disorder, Single Episode, Severe</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Without Psychotic Features.</td>
</tr>
<tr>
<td>Axis II</td>
<td>305.00</td>
<td>Alcohol Abuse</td>
</tr>
<tr>
<td>Axis III</td>
<td>301.6</td>
<td>Dependent Personality Disorder.</td>
</tr>
<tr>
<td>Axis IV</td>
<td>None</td>
<td>Threat of job loss.</td>
</tr>
<tr>
<td>Axis V</td>
<td>GAF=35</td>
<td>(current)</td>
</tr>
</tbody>
</table>

3–8:07 Use of the “Not Otherwise Specified” Categories

The DSM system created the Not Otherwise Specified [hereinafter NOS] category because the diversity of clinical pictures made it impossible to categorize every clinical situation\footnote{DSM–IV 4.}—some patients’ symptoms “fall through the cracks” of the DSM–IV system.\footnote{ALLEN FRANCES, MICHAEL B. FIRST & HAROLD A. PINCUS, DSM–IV GUIDEBOOK 59 (1995).} Consequently, each DSM–IV diagnostic class has at least one NOS category. For example, after the listing of the Axis II Personality Disorders, DSM–IV lists a category titled, Personality Disorder Not Otherwise Specified. DSM–IV lists four situations in which an NOS diagnosis may be appropriate:\footnote{DSM–IV 4.}

- The patient presentation conforms to the general guidelines for a mental disorder in the diagnostic class, but the symptom picture does not meet the criteria for any of the specific disorders.
- The patient presentation conforms to a symptom pattern that has not been included in the DSM–IV classification but that causes clinically significant distress or impairment. Appendix B in DSM–IV, titled Criteria Sets and Axes Provided for Further Study, contains criteria for some of these symptom patterns. Disorders in Appendix B are not official diagnostic categories of DSM–IV.
- The mental health professional is uncertain about the disorder’s etiology, for example, whether the disorder is due to a general medical condition, is substance induced, or is primary.
- There is insufficient opportunity for complete data collection or inconsistent or contradictory information, but there is enough information to place the disorder in a particular diagnostic class.

3–8:08 How is a DSM–IV Diagnosis Communicated?

When communicating a diagnosis of a patient, a mental health professional will not always report information on all five axes. Remember, a multiaxial system provides a format for organizing and communicating clinical information, for capturing the complexity of clinical situations, and for describing the heterogeneity of individuals presenting with the same diagnosis.\footnote{DSM–IV 25.} All of this information about a patient may not be necessary to report to another interested party. For example,

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41 DSM–IV 30–32.
42 DSM–IV 4.
44 DSM–IV 4.
45 DSM–IV 25.
diagnoses for insurance reimbursement purposes usually require an Axis I diagnosis, and, sometimes, but not commonly, an Axis II Personality Disorder diagnosis; Axis I and Axis II are the primary mental disorder dimensions of the full diagnosis. Although DSM–IV recommends the use of the multiaxial system and provides definitions for each of the five axes, it makes clear its use is optional and provides several alternative axes that may also be useful in particular settings. The DSM–IV expressly allows clinicians who do not wish to use the multiaxial format simply to list the appropriate diagnoses. Like most of DSM–IV, the multiaxial system is useful if tempered by clinical judgment and common sense.

3–8:09 How is the Clinical Significance of a DSM–IV Mental Disorder Determined?

The DSM–IV definition of Mental Disorder requires that there be clinically significant impairment or distress in social, occupational, or other important areas of functioning. This criterion of significant impairment or distress helps to establish the diagnostic threshold for a mental disorder in situations in which a symptomatic presentation (particularly in its milder forms) is not inherently pathological and may be encountered in individuals for whom a diagnosis of “mental disorder” would be inappropriate. Assessing whether this criterion is met is an inherently difficult clinical judgment. There is no specific empirical data to inform this decision. Consequently, one cannot underestimate the role of clinical judgment in making such determinations.

46 Allen Frances, Michael B. First & Harold A. Pincus, DSM–IV Guidebook 85 (1995). Also, the optional axes included in DSM–IV Appendix B are the Defensive Functioning Scale, the Global Assessment of Relational Functioning Scale (GARF), and the Social and Occupational Functioning Assessment Scale (SOFAS). While these ratings may provide useful information in a clinical setting, their legal reliability, as in the Axes IV and V, are questionable, at best.

47 DSM–IV 35.


49 DSM–IV 7. The DSM–IV definition of Mental Disorder: “Each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (e.g. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual, as described above.” DSM–IV xxiv–xxv. See also Allen J. Frances, Michael B. First, Thomas A. Widiger, Gloria M. Miele, Sarah M. Tilly, Wendy W. Davis & Harold A. Pincus, An A to Z Guide to DSM–IV Conundrums, 100 J. Abn. Psychol. 407 (1991): “(Mental Disorder) could not be a more unfortunate term, preserving as it does an outdated mind-body duality. There is much that is physical in the so-called mental disorders, and much mental in the so-called physical disorders.”

50 DSM–IV 7.

51 DSM–IV 7.

52 See also Allen Frances, Michael B. First & Harold A. Pincus, DSM–IV Guidebook 60 (1995).
3–8:10 Admissibility of DSM–IV Under Robinson/Gammill.

3–8:10(1) The Legal Backdrop

As noted in other chapters in this manual, the line of cases highlighted by Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579 (1993), E.I. duPont de Nemours and Co. v. Robinson, 923 S.W.2d 549, 556 (Tex. 1995), and Gammill v. Jack Williams Chevrolet, 972 S.W.2d 713 (Tex. 1998) emphasize that scientific testimony must be relevant and reliable to be admitted under Rule 702 of the Texas Rules of Evidence. Robinson proposed several non-exclusive factors for the court to consider in making the threshold determination of admissibility of scientific expert testimony under Rule 702.\(^{53}\) These factors include, but are not limited to:

- the extent to which the theory has been or can be tested;
- the extent to which the technique relies upon the subjective interpretation of the expert;
- whether the theory has been subjected to peer review and/or publication;
- the technique’s potential rate of error, e.g. false positives/false negatives;
- whether the underlying theory or technique has been generally accepted as valid by the relevant scientific community; and
- the non-judicial uses which have been made of the theory or technique.

Gammill noted that while the relevancy and reliability principles of Robinson and Daubert applied even to “advertising psychology,” “(T)he court should ensure that the opinion comports with applicable professional standards outside the courtroom and that it (the opinion) ‘will have a reliable basis in the knowledge and experience of the discipline.’”\(^{54}\) Gammill noted that because the Robinson factors are non-exclusive, “trial courts may consider other factors which are helpful to determining the reliability of the scientific evidence.”\(^{55}\) However, there must be some basis for the opinion offered to show its reliability. A court may conclude that there is simply too great an analytical gap between the data and the opinion proffered.\(^{56}\) The court is not required to admit opinion evidence which is connected to the existing data only by the ipse dixit of the expert.\(^{57}\)

In Nenno v. State,\(^{58}\) the Texas Court of Criminal Appeals ruled on the application of Daubert principles of reliability and relevancy to expert testimony. The question was whether the Court’s holding in Kelly v. State,\(^{59}\) a pre-Daubert application of legal reliability standards to scientific evidence, was applicable to nonscientific testimony. The Nenno Court held that the answer to the

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\(^{53}\) E.I. duPont de Nemours and Co. v. Robinson, 923 S.W.2d 549, 556 (Tex. 1995).

\(^{54}\) Gammill v. Jack Williams Chevrolet, 972 S.W.2d 713, 725-726 (Tex. 1998), also citing Watkins v. Telsmith, Inc., 121 F.3d 984,991 (5th Cir. 1997).

\(^{55}\) Gammill v. Jack Williams Chevrolet, 972 S.W.2d 713, 720 (Tex. 1998).

\(^{56}\) Gammill v. Jack Williams Chevrolet, 972 S.W.2d 713, 726 (Tex. 1998).

\(^{57}\) Gammill v. Jack Williams Chevrolet, 972 S.W.2d 713, 727 (Tex. 1998).


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question was a “qualified ‘yes.’”\textsuperscript{60} Nenno emphasized that the Daubert inquiry is “flexible,” and that Daubert did not presume to set out a definitive checklist or test. Nenno further noted that “when addressing fields of study aside from the hard sciences, such as the social sciences or fields that are based primarily upon experience and training as opposed to the scientific method, Kelly’s requirement of reliability applies but with less rigor than to the hard sciences.”\textsuperscript{61} Nenno stated that appropriate questions to gauge reliability in non-hard science fields are: 1) whether the field of expertise is a legitimate one; 2) whether the subject matter of the expert’s testimony is within the scope of that field; and 3) whether the expert’s testimony properly relies upon and/or utilizes the principles involved in the field. Nenno fashioned these questions as an “appropriately tailored translation of the Kelly test to areas outside of hard science.”\textsuperscript{62}

In a March 1999 case, Kumho Tire Co. v. Carmichael, the U.S. Supreme Court noted that Daubert’s general principles applied in federal courts to all expert testimony covered by Fed. R. Evid. 702, not just “scientific knowledge.”\textsuperscript{63} However, the Court stated that “a trial court should consider the specific factors identified in Daubert where they are reasonable measures of the reliability of expert testimony.”\textsuperscript{64} The Court noted, “(W)hether Daubert’s specific factors are, or are not, reasonable measures of reliability in a particular case is a matter that the law grants the trial judge broad latitude to determine.”\textsuperscript{65} Nevertheless, the Court emphasized that the objective of the Daubert requirement “is to ensure the reliability and relevancy of expert testimony.”\textsuperscript{66} In Kumho Tire’s holding, the Court upheld the trial court’s discretion when the trial court ruled that the expert’s opinion in the case was inadmissible because the expert’s methodology in analyzing data upon which he based his opinion was unreliable despite the expert’s acceptable qualifications.\textsuperscript{67} The Court invoked Joiner in noting that nothing in either Daubert or the Federal Rules of Evidence requires a district court to admit opinion evidence that is connected to existing data only because the expert says it is so.\textsuperscript{68}

\textsuperscript{60} Nenno v. State, 970 S.W.2d 549, 560 (Tex. Crim. App. 1998).

\textsuperscript{61} Nenno v. State, 970 S.W.2d 549, 561 (Tex. Crim. App. 1998).


\textsuperscript{63} Kumho Tire Co. v. Carmichael, 526 U.S. ___ (1999), No. 97-1709, slip op. at 7 (U.S. March 23, 1999).

\textsuperscript{64} Kumho Tire Co. v. Carmichael, 526 U.S. ___ (1999), No. 97-1709, slip op. at 12 (U.S. March 23, 1999).

\textsuperscript{65} Kumho Tire Co. v. Carmichael, 526 U.S. ___ (1999), No. 97-1709, slip op. at 13 (U.S. March 23, 1999).


\textsuperscript{67} Kumho Tire Co. v. Carmichael, 526 U.S. ___ (1999), No. 97-1709, slip op. at 19 (U.S. March 23, 1999).


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Finally, a Fifth Circuit post-*Kumho Tire* case, *Black v. Food Lion*, seemed to draw some limits on interpretations of *Kumho Tire* that would undermine the use of the specific *Daubert* factors as a reference point for gauging the reliability of an expert’s testimony. The *Black* court appeared to elevate the “non-exclusive” *Daubert* factors as primary considerations in assessing reliability, noting that “in the vast majority of cases, the district court first should decide whether the factors mentioned in *Daubert* are appropriate. Once it considers the *Daubert* factors, the court then can consider whether other factors not mentioned in *Daubert* are relevant to the case. 

3–8:10(2) Support for Admissibility of DSM–IV

3–8:10(2)(a) General Acceptance for Clinical and Research Uses

DSM–IV is the primary diagnostic classification system for mental disorders used in the United States. One author—a DSM–IV Task Force member—asserted that more than 500,000 mental health professionals use the DSM–IV in their practices. In addition, DSM–IV is largely compatible with ICD–10 classification system, published by the World Health Organization and used by mental health professionals outside the United States. Consequently, the applicable professional standards test of *Gammmill* suggests that DSM–IV is generally accepted as valid as a diagnostic system by the relevant scientific community.

3–8:10(2)(b) Peer Review

DSM–IV was developed by a large group of mental health professionals making use of the available empirical and clinical research literature to decide on the various mental disorder categories. Thus, DSM–IV has been subjected to peer review as a whole, and much of the empirical literature informing the decisions of the DSM–IV committees involved empirical studies with testable theories.

3–8:10(3) Arguments against Admissibility of DSM–IV

3–8:10(3)(a) DSM–IV was not Designed for Use in Court

DSM–IV was developed primarily for clinicians, educators, and researchers to provide an accepted system for communication about mental disorders and to provide a basis for treatment planning. While DSM–IV diagnostic information can assist decision-makers in legal settings, DSM–IV warns that “dangers arise because of the imperfect fit between questions of ultimate concern to the law and the information contained in a clinical diagnosis.” In other words, one cannot correlate specific DSM–IV Mental Disorders with specific legal concepts such as insanity or competency or even best interest of the child. Beyond a DSM–IV diagnosis, information about the

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69 *Black v. Food Lion*, 171 F.3d 308 (5th Cir. 1999).

70 *Black v. Food Lion*, 171 F.3d 308 (5th Cir. 1999).


72 See § 3–8:02 of this chapter.

73 See § 3–8:04 of this chapter.

74 DSM–IV xxiii.
person’s functional impairments and how those impairments affect the particular abilities in question is important in court. It is precisely because impairments, abilities, and disabilities vary widely within each diagnostic category that assignment of a particular diagnosis does not imply a specific level of impairment or disability.  

3–8:10(3)(b) DSM–IV’s Emphasis on Clinical Judgment for Diagnosis

DSM–IV places a heavy emphasis on the clinical judgment of the mental health professional in making a diagnosis of a mental disorder. Mental disorders in DSM–IV are defined as clinically significant behavioral or psychological syndromes causing distress or disability—for example, impairment in functioning. The syndrome must not be an expected response to a particular event. One criticism of this definition is that it is vague in setting the boundary between clinically significant psychopathology and the aches and pains of normal life. DSM–IV appeals to clinical judgment by including the following item as a requirement in the criteria sets of dozens of disorders: “The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.” This appeal is a reminder to evaluate not only the presence of the symptoms in the criteria set, but also whether the symptoms are severe enough to constitute a mental disorder. As noted earlier in this chapter, clinical judgment is informed by the clinician’s training and experience in diagnosis. This begs the question about how much clinical judgment informs the diagnosis. Although DSM–IV answers the question by emphasizing that neither clinical judgment or the diagnostic criteria should override each other, no formula is offered to gauge the relative contributions of each in a given diagnostic decision. Clinical judgment introduces a subjective element to the diagnostic process, albeit, preferably, trained. And, one of the Robinson factors notes that the court can assess “the extent to which the technique relies upon the subjective interpretation of the expert.” The more the mental health expert relies on her judgment at the expense of the diagnostic criteria, the more this particular Robinson factor suggests that the diagnosis should be inadmissible.

75 DSM–IV xxiii; See also discussion of T. Grisso model of organizing evaluation information in § 3–80:05(3) of this manual.


79 DSM–IV xxiii.

80 See Allen J. Frances, Michael B. First, Thomas A. Widiger, Gloria M. Miele, Sarah M. Tilly, Wendy W. Davis & Harold A. Pincus, An A to Z Guide to DSM–IV Conundrums, 100 J. ABN. PSYCHOL. 407 (1991): “If clinicians do not exercise clinical judgment, they will be slavishly following a system with admittedly and necessarily arbitrary boundaries. On the other hand, the excessively flexible and idiosyncratic application of the system (or ignorance of it) substantially reduces its utility as a common language for communication among clinicians and across the research-clinical interface.”

81 E.I. duPont de Nemours and Co. v. Robinson, 923 S.W.2d 549, 556 (Tex. 1995).

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3–8:10(3)(c) Some DSM–IV Disorders May Not be Clearly Definable

Despite the purported scientific foundation of DSM–IV, DSM–IV classifications, in themselves, may not be clearly definable in certain cases. “Mental disorders are neither homogeneous nor divided by clear boundaries ... (T)here is considerable heterogeneity of the presentations encountered even within each disorder, and the boundaries between disorders are often fuzzy.” At issue is the idea of classifying by categories instead of by dimensions. Categories have clear boundaries and all members of the class are homogeneous with regard to their defining characteristics; you are either in one category or the other. Dimensions can be more precise when describing a variable that is distributed on a continuum, although the boundaries between classifications may be more “fuzzy” and confusing. For example, in one person, a personality disorder may be less severe and seem “normal,” while in another person that disorder could be more severe and clearly pathological. While DSM–IV follows the traditional approach of using categorical methods of diagnosis, it recognizes that dimensional methods may more accurately classify some mental disorders.

Instead of considering categories or dimensions, some mental health professionals view disorders as prototypes, essentially bridging the categorical and dimensional approaches. In the prototype approach, characteristics of a disorder are seen as prototypical, or ideal, forms of the disorder, and individuals classified within the disorder are expected to vary greatly in the degree to which they resemble the prototype. For example, while most persons with an Antisocial Personality Disorder may have similar characteristics of the disorder, not all have the exact same number or kinds of characteristics, allowing for differing types of manifestations of Antisocial Personality Disorder. While DSM–IV settled on the more traditional categorical approach with strong “nods” to dimensional ways of classifying mental disorders, a consensus has not been established on a preferred classification model.

3–8:10(3)(d) DSM–IV’s Arbitrary Thresholds for Diagnoses

Determinations by the DSM–IV workgroups about how a DSM–IV category would be defined suggest reliability problems. While cut-off points which determine a person’s membership in the category are necessary to provide an understanding for clinical and research communication, they are to a great degree arbitrary. The thresholds established for most of the DSM–IV disorders were originally chosen as best guesses arrived at by expert consensus. Each threshold was established to provide an optimal balance between false-positive (persons classified with a disorder who actually do not have the disorder) and false-negative (persons not classified with a disorder who actually have the disorder) diagnoses. To avoid excessive false-positives, the thresholds had to be set relatively high, necessarily resulting in unavoidable false-negatives. Hence, the emphasis on clinical judgment in the diagnosis of a DSM–IV mental disorder.


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3–8:10(3)(e) The Issue of Comorbidity

The DSM–IV categorical approach encounters problems with comorbidity, that is, the co-occurrence of two or more disorders in the same individual. Researchers have noted that there are widespread comorbidities among the DSM–IV disorders, particularly among the Personality Disorders. This raises questions about whether some disorders can be reliably distinguished from other disorders. Nevertheless, these comorbidities have important diagnostic and treatment implications.88 Contrary to what someone might expect when turning to DSM–IV, research data suggest that pure, unmixed cases are not likely to be representative of the overall population of individuals with a disorder, particularly in the Axis II Personality Disorders. Moreover, individuals with comorbid conditions differ from pure cases.89 Most notably, individuals with comorbid conditions generally have a more chronic and complicated course, poorer prognosis, and lessened response to treatment.90

3–8:10(3)(f) The Problem of Within-Category Heterogeneity

DSM–IV’s categorical approach also has problems of within-category heterogeneity. Within-category heterogeneity in DSM–IV diagnoses occur because some disorders require the meeting of a certain number of criteria among several options. Consequently, two patients could be diagnosed with the same disorder based on different criteria. For example, the nine criteria for Borderline Personality Disorder reflect a wide range of personality trait dimensions, from uncontrollable anger to identity disturbance. Two patients who meet criteria for the diagnosis may share all nine criterion traits or they may share only one of the required five criteria and exhibit rather different personality pathologies.91 Other examples: for Conduct Disorder, three criteria out of 15 must be met; for Dysthymia, two criteria out of five must be met; and for Premenstrual Dysphoric Disorder, five criteria out of 11 must be met.

One should note that comorbidity and heterogeneity are related issues. Problematic comorbidity exists, in part, because patients differ widely—that is, they show within-group heterogeneity—in diagnostic features that are shared across diagnoses.92

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3–8:10(3)(g) DSM–IV Does Not Support Causation and Diagnosis

DSM–IV cautions that a diagnosis does not carry any necessary implications about the causes of the individual’s mental disorder or its associated impairments. Even when diminished control over one’s behavior is a feature of the disorder, having the diagnosis in itself does not demonstrate that a particular individual is (or was) unable to control his or her behavior at a particular time.93

3–8:10(3)(h) DSM–IV has No Underlying Supporting Theory

DSM–IV purports to be atheoretical; it does not espouse any particular theory of the causes of mental disorders. As a result, DSM–IV is reduced to syndrome diagnosis, a legacy from physical medicine which requires the clinician to observe, record, and process disease symptoms until a sufficient number to signal the presence of a disease syndrome has been observed.94 While no viable alternative diagnostic system to classify psychopathology on bases other than symptoms has gained a foothold in the field,95 DSM–IV does not fit well with a great deal of empirical research that psychology has generated in understanding human behavior.96 For example, the same behavior can have different purposes or meanings across individuals, while different behaviors may serve the same purpose in a particular individual. Without a theory of “why?”, many diagnoses make little sense. But if DSM–IV were to espouse a theory of causes, its acceptance in the mental health field would be less.97

3–8:10(3)(i) DSM–IV Represents a 1994 Understanding of Mental Disorders

The classification and diagnosis of mental disorders reflect a consensus opinion at the time of publication (1994), open to reconsideration in light of evolving information. The text and diagnostic criteria sets included in DSM–IV will require reconsideration in light of evolving new information.98 For example, characteristics of some disorders have been dropped and/or added from one edition to the next.

3–8:11 Conclusion

DSM–IV represents the latest installment of an evolving diagnostic system of Mental

93 DSM–IV xxiii.

94 Peter E. Nathan, In the Final Analysis, It’s the Data that Count, 4 CL. PSYCHOL.: SC. & PRACT. 281, 282 (1997).

95 Peter E. Nathan, In the Final Analysis, It’s the Data that Count, 4 CL. PSYCHOL.: SC. & PRACT. 281, 282 (1997).


97 See William C. Follette & Arthur C. Houts, Models of Scientific Progress and the Role of Theory in Taxonomy Development: A Case Study of the DSM, 64 J. CONSULT. & CLIN. PSYCHOL. 1120 (1996). Follette & Houts assert that the framers of DSM–IV (primarily the American Psychiatric Association) adopted an ostensible atheoretical position to diagnosis so that DSM–IV would be widely accepted, essentially co-opting opposition from other mental health professionals, primarily psychologists, who did not support a medical model approach to mental disorders.

98 DSM–IV xxiii.

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Disorders. The process began in 1952 with DSM–I as a compendium of disorders compiled by a small number of psychiatrists. DSM–IV’s classifications are more informed by empirical research and by the considerations of a broader group of mental health professionals. DSM–IV is the dominant system in the United States for diagnosing Mental Disorders.

While DSM–IV’s acceptance is widespread, its classification system has generated much debate. The debate has fostered much research in psychopathology and has focused mental health professionals on the empirical and clinical bases for various Mental Disorders. In addition, DSM–IV has provided mental health professionals with categorical language with which to communicate and think about Mental Disorders and to develop treatment plans for patients.

While DSM–IV has been useful to the mental health clinician, DSM–IV offers caveats to its use in court. Consequently, while arguments can be made to support DSM–IV’s admissibility in court, the specific use of DSM–IV by the testifying expert may be challenged if that expert does not adequately account for the problems inherent in the DSM scheme or if that expert uses DSM–IV solely for the basis of her opinion.