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CHAPTER 10

Exposing Misuse of DSM-5
A Lawyer's Approach

Introduction

Borderline Personality Disorder. Narcissistic Personality Disorder. Bipolar Disorder. Diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition* (DSM-5)[1] quickly catch a judge's or jury's ear—and often raise concerns. Use of DSM-5 in family court raises important questions: Do these diagnoses adequately describe the nature of parents' or children's problems in family law cases? Does applying diagnostic labels to describe parents and children fit the functional approach (assesses the parents' capacities, the child's needs, and the resulting fit that best meets the child's needs) that should be used to make child custody decisions?[2] Do DSM-5 diagnoses give rise to evidentiary concerns?

Making sense of DSM-5 to answer these questions can be daunting. Even mental health professionals are confused by the density of information in DSM-5. To orient yourself to key DSM-5 issues, start with Section I of DSM-5. Be assured that many mental health experts will not be familiar with that content. Section I offers an overview of the purpose, structure, content, and use of DSM-5,[3] providing key material on which to base effective critiques of DSM-5 diagnosis-based testimony.

1. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition (2013) [hereinafter DSM-5].
2. *See* Chapter 3; *see also* American Psychological Association, *Guidelines for Child Custody Evaluations in Family Law Proceedings,* Guideline 3, 65 Am. Psychol. 863, 864 (2010).
3. DSM-5, at 3.

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This chapter, largely based on Section I of DSM-5, takes a lawyer's approach to DSM-5 diagnoses. Neither an overview of DSM-5 diagnoses nor a review of all the diagnostic changes from DSM-IV-TR will be covered; lawyers should retain a board-certified forensic psychiatrist (ABPN) or a board-certified forensic psychologist (ABPP) to understand particular mental disorders at issue in a given case and the research related to those disorders. Instead, we will approach DSM-5 in a manner similar to the way lawyers regularly approach experts' opinions: by highlighting the purposes of DSM-5, by discussing the methodology that the DSM-5 developers used to shape the DSM-5 product, and by explaining DSM-5's process for determining diagnoses. In sum, experts who invoke DSM-5 diagnoses to support their testimony still must answer this book's key orienting question: "How do you know what you say you know?" This approach will bring the expert into the lawyer's arena, where you can first address the expert's methods and reasoning for determining a diagnosis. Then, rather than wrestling with experts on whether specific diagnostic criteria apply, you can fashion reliability-based questions to experts that inform the court about whether it can trust the expert's testimony.

This chapter helps to fashion those questions within the framework set out earlier in this book: understanding separately the psychological and legal perspectives of DSM-5-related testimony and then integrating information from each perspective to sharpen critiques of that testimony.

To understand the psychological and legal perspectives separately, we will focus on three topics, the first two of which represent the psychological perspective. First, we will note the purposes of DSM-5 and summarize its development. Second, we will examine the elements of a DSM-5 diagnosis. Third, we will marshal the legal perspective to analyze DSM-5 issues from caselaw and the rules of evidence.

After addressing the psychological and legal perspectives separately, we will integrate the information from those perspectives to show how you can support or challenge DSM-5 issues in depositions, in direct or cross-examinations of experts, and in your arguments to the court.

Topic One: Purposes and Development of DSM-5

DSM-5 is the most prominent diagnostic system used by American mental health professionals to classify mental disorders. Outside the United States, the *International Classification of Disorders* (ICD), published by the World Health Organization, is used to classify medical and mental disorders. You may become a bit confused when you realize that ICD-9-CM is the HIPAA-approved coding system for mental disorders; ICD-10-CM is scheduled to be implemented in the United States in late 2015. However, mental health experts will likely continue to use DSM definitions and criteria when they invoke diagnoses

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in their testimony. Many DSM-5 diagnoses correspond to ICD-9-CM and ICD-10-CM diagnoses, even listing ICD-10-CM diagnosis numbers next to the corresponding DSM-5 numbers in the DSM-5 manual. DSM-5 also claims that the work groups developing DSM and ICD will seek to continue harmonizing the two systems "as much as possible."[4]

The DSM franchise has markedly influenced the mental health industry and public policy: who gets diagnosed, how patients are treated, who pays for the treatment, how dollars and resources are allocated to address mental health and disability concerns.[5] Yet DSM-5 misconceptions abound. For example, in the run-up to the May 2013 publication of DSM-5, the media often touted it as the "bible of psychiatry." Lawyers, trying to bolster DSM-oriented testimony, make similar claims in court. In reality, DSM-5 is but an imperfect, evolving guide—a living document[6]—to inform and define psychiatric diagnosis.[7] Understanding the purposes and development of DSM-5 is an important first step to help you ensure that mental health experts use DSM-5 diagnoses properly in their testimony.

Purposes of DMS-5

Knowing the purposes for which DSM-5 was developed and how it is used by mental health professionals outside the courtroom is critical. Experts who disregard the intended purposes of DSM-5 when they invoke DSM-5 diagnoses in their testimony open themselves up to sharp legal relevance- and reliability-based questions.

DSM-5 is used for at least three primary purposes. First, mental health clinicians, researchers, and educators use DSM-5 as a common language with which to communicate patient concerns and other diagnostic issues related to mental disorders, as well as to conduct research.[8] Second, clinicians use DSM-5 to plan mental health treatment of patients and to anticipate treatment outcomes.[9] In addition, the health care and insurance industries have used DSM-5 as a reference with which to reimburse mental health treatment costs.

A key issue, discussed later in this chapter, is that DSM-5 was not developed to be used in court. Although DSM-5 notes that its diagnostic information can assist legal decision-making, it cautions about the "risk that diagnostic information will be misused or misunderstood" in the legal system[10]—a warning that makes sense in family law cases where diagnoses are often used to mischaracterize parents' abilities to care for their

4. DSM-5, at 11.
5. Allen J. Frances & Thomas Widiger, *Psychiatric Diagnosis: Lessons from the DSM-IV Past and Cautions for DSM-5 Future,* 8 Ann. Rev. Clinical Psychol. 7.1, 7.2 (2012).
6. DSM-5, at 13.
7. Frances & Widiger, *supra* note 5, at 7.7.
8. DSM-5, at 20.
9. *Id.*; Joseph R. Scotti, Tracy L. Morris, Cheryl B. McNeil, & Robert P. Hawkins, *Can Structural Criteria Be Functional?*, 64 J. Consulting & Clinical Psychol. 1177 (1996).
10. DSM-5, at 25.

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children. *Daubert* also cautions that testimony considered valid for one purpose is not necessarily valid for another purpose.[11]

In sum, note the purpose for which the expert invokes a DSM-5 diagnosis—e.g., properly, to describe a clinical condition; properly, to forecast a treatment regimen; improperly, to determine, instead of inform, an opinion about whether a parent should have primary custody of the child. Noting the expert's purpose for using a DSM-5 diagnosis begins the process of determining the relevance and reliability of the expert's testimony.

Development of DSM-5

A Brief History

The DSM, developed and published by the American Psychiatric Association, has been through five major editions.[12] Each DSM edition expanded on the previous one, with more diagnostic categories and changed or new criteria for various disorders with each edition.

DSM-III, published in 1980, marked a significant change from the previous DSM editions, a change that is reflected in DSM-5. DSM-I and DSM-II were merely compendia of narrative descriptions of various psychiatric disorders; each disorder was included in the manual by consensus of a small number of psychiatrists.[13] Application of diagnoses from these early editions was often inconsistent and unreliable.[14] DSM-III was designed to remedy this problem. DSM-III grew out of psychiatric research in the 1970s that developed explicit symptom-based criteria with which to define mental disorders.[15] The changes in DSM-III moved the determination of psychiatric diagnoses from the subjective judgments of DSM-I and -II to a more empirical, symptom-based criteria approach. The development of DSM-IV built on DSM-III-R (the 1987 revised edition) and involved a substantially larger and more diverse group of MHPs than previous DSM editions used and was even more empirically based than the previous editions. Although DSM-5 continues to define diagnoses by utilizing the symptom-based criteria approach that DSM-III instituted, DSM-5 tried to incorporate more "dimensional" reporting of some diagnoses (e.g., noting mild, moderate, or severe levels of a diagnosis or criterion) rather than solely "categorical" reporting of diagnoses (e.g., whether the patient should be assigned

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11. Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579, 591 (1993).

12. DSM-5, the current edition, was published in May 2013; the first edition was published in 1952. DSM-IV was published in 1994; the DSM-IV Text Revision (DSM-IV-TR) was released in 2000 to update research support for some DSM-IV diagnostic criteria, although no substantive changes to DSM-IV's criteria were considered. Previous DSM editions included DSM-I (published in 1952), DSM-II (published in 1968), DSM-III (published in 1980), and DSM-III-R (a revision published in 1987).

13. Peter E. Nathan, *The DSM-IV and Its Antecedents: Enhancing Syndromal Diagnosis*, in Making Diagnosis Meaningful 3, 6 (J.W. Barron ed., 1998).

14. K. Doyle Jones, *A Critique of the DSM-5 Field Trials*, 200 J. Nervous & Mental Disease 517, 519 (2012).

15. Allen Frances, Michael B. First, & Harold A. Pincus, DSM-IV Guidebook 34 (1995).

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the diagnosis). The important issue of categorical versus dimensional diagnosis reporting will be addressed later in this chapter.

How Was DSM-5 Developed?

Understanding how DSM-5 was developed offers an important context for examining experts who invoke DSM-5 diagnoses in their testimony. To begin: Who worked on the undertaking? How were critical decisions made during the development process?

Two primary entities, under the auspices of the American Psychiatric Association, developed DSM-5: a main Task Force and a set of 13 work groups, each work group composed of experts in a particular diagnostic area.[16] DSM-5 lists 31 members as having served on the Task Force[17] and more than 130 members in the work groups.[18] In addition, more than 400 "nonvoting members" served as work group advisors.[19] Other appointed groups also contributed.[20]

The Task Force, headed by a chair and vice chair, directed the DSM-5 project. The Task Force considered changes from DSM-IV-TR that the work groups proposed and, with the work groups, reviewed text describing each disorder. The Task Force also judged the scientific merits of additions and revisions proposed by the work groups.[21] Finally, the Task Force presented final recommendations to the American Psychiatric Association's governing entities for approval.[22]

Some DSM-5 critics highlight the composition of the Task Force as a fundamental problem with DSM-5. They argue that "Who was in the room" when DSM-5 issues were addressed colored decisions regarding diagnoses and their descriptions. For example, of the 31 listed Task Force members, 26 have MD degrees specializing in psychiatry.[23] Also, 81 percent of Task Force members were male.[24] Given DSM-5's status as the "benchmark" for diagnosis of mental disorders, the overrepresentation of male psychiatrists on the Task Force is notable.[25] In addition, the mental health profession includes other disciplines—e.g., psychology, professional counseling, social work—that were hardly represented in the project's decision-making. Further, disclosure statements indicated that 70 percent of

16. The 13 DSM-5 workgroups included ADHD and Disruptive Behaviors; Anxiety, Obsessive-Compulsive Spectrum, Posttraumatic, and Dissociative Disorders; Childhood and Adolescent Disorders; Eating Disorders; Mood Disorders; Neurocognitive Disorders; Neurodevelopmental Disorders; Personality and Personality Disorders; Psychotic Disorders; Sexual and Gender Identity Disorders; Sleep-Wake Disorders; Somatic Symptoms Disorders; and Substance-Related Disorders.
17. DSM-5, at vii.
18. *Id.* at 7, viii–x.
19. *Id.*
20. DSM-5, at xi–xii.
21. *Id.* at 9.
22. *Id.*
23. DSM-5, at viii–x.
24. *Id.*
25. Laura Howe-Martin, *Values and Psychiatric Diagnosis* (Paper presented at the University of Texas Southwestern Medical School conference, Diagnostic Changes, Values, and Alternatives (July 20, 2013)).

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the Task Force had pharmaceutical industry ties, as did more than 50 percent of work group members, raising concerns about drug company influences on decisions about criteria for several diagnoses.[26]

Although DSM-5 directives and decisions were centered in the Task Force, the diagnostic "sausage-making" was done in the 13 work groups. Each work group, composed of experts in primary diagnostic categories, reviewed research literature and proposed changes in diagnostic names, descriptions, or criteria, if such were called for.[27] Some proposed changes included merging previously separate diagnostic labels into broader, umbrella-like spectrums.

In addition to reviewing the research literature and proposing reformulated or new diagnoses, the work groups authorized field trial testing to assess the feasibility and clinical utility of proposed diagnosis changes or new diagnoses.[28] Field trial issues, however, contributed to concerns about DSM-5.[29] Field trials were conducted in two types of settings: large, diverse medical-academic settings and routine clinical practices.[30] In sum, the planned field trial methods included the following steps: (1) independent interviews by two different clinicians trained in the diagnosis being investigated, in which each clinician was blind to the subject's diagnosis and prompted by a computerized checklist; and (2) assessment of how much clinicians' ratings of diagnoses being investigated agreed across the different academic settings involved in the field trials."[31] These field trials required that the clinician determine a diagnosis from a single patient interview with minimal collateral information.[32] The routine clinical practice field trials used psychiatrists and other mental health clinicians recruited for the studies.[33]

However, problems attended the field trials. DSM-5 notes that "comprehensive testing of all proposed changes could not be accommodated by such testing because of time limitations and availability of resources"[34]—bluntly, the DSM-5 project ran out of time and money to conduct the field trials as initially contemplated. Sharp critiques of the field studies in the psychiatric literature expanded on DSM-5's admission. One review noted significant problems with the planning, methodology, and implementation of the field trials: "[T]hey were poorly planned, started late, used the wrong testing sites, were disorganized in administration, constantly missed deadlines, did not evaluate validity, did not evaluate prevalence rate changes, had an extremely high attrition rate in the routine

26. *Id.*
27. DSM-5, at 9.
28. *Id.*
29. DSM-5, at 7.
30. *Id.* at 7–8.
31. Robert Freedman et al., *The Initial Field Trials of DSM-5: New Blooms and Old Thorns*, 170 Am. J. Psychiatry, 1 (2013).
32. *Id.* at 3.
33. DSM-5, at 8.
34. *Id.* at 9.

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trials, and may well have unacceptably low reliabilities."[35] In addition, the single patient interview with minimal collateral information that the field trial clinicians conducted is different than the information gathering that clinicians customarily conduct in their offices when they determine what diagnoses apply to their patients.

Finally, not all field trials that were conducted produced highly consistent diagnosis ratings among the clinicians, and no process was used to assess reasons for the inconsistency of those ratings.[36] Statistical reliability (consistency of clinician ratings) in the application of diagnoses is important for two reasons: First, if clinicians have difficulty agreeing as to which DSM-5 diagnosis best fits a patient's condition, mental health experts who use DSM-5 in their practices might also disagree. Second, a basic statistical premise is invoked: statistical reliability is a condition for validity. If professionals in the field trial studies cannot agree about whether the patient has a particular diagnosis, there is little basis for accepting the validity, or trustworthiness, of that diagnosis.

Three examples of diagnoses that may appear in family law cases illustrate some of the foregoing concerns: Attention deficit hyperactivity disorder, Asperger's disorder, and Personality disorders. Let's briefly look at issues in each diagnosis.

Attention deficit hyperactivity disorder (ADHD). Popular and academic literature teems with assertions that physicians, mental health professionals, and teachers overdiagnose ADHD. What separates an active child from an ADHD child, particularly if the ADHD child is diagnosed at a "mild" or "moderate" level? The distinctions could determine whether a child is placed in special education classes, labeled as a behavior problem child, prescribed medicine, or all of the above.

Definitions and criteria for ADHD have changed across DSM editions.[37] For example, DSM-III-R required a set number of criteria that reflected "developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity" that usually appear in most situations in which the child engages.[38] Symptoms might worsen when the child is required to sustain attention, as in a classroom, but might be absent when the child is reinforced frequently or when the child's behavior is strictly controlled.[39] If endorsed, the severity of these symptoms would be rated as mild, moderate, or severe.[40] Onset of these behaviors must have occurred before the age of seven.[41]

35. Jones, *supra* note 14, at 519.
36. *Id.* at 518.
37. Laura Batstra & Allen Frances, *DSM-5 Further Inflates Attention Deficit Hyperactivity Disorder*, 200(6) J. Nervous & Mental Disease 486, 486 (2012).
38. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders—Third Edition-Revised 50 (1987) [hereinafter DSM-III-R].
39. *Id.*
40. DSM-III-R at 53.
41. *Id.*

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DSM-IV modified the previous edition's ADHD definition, stating that the essential feature of ADHD "is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development."[42] Note that the "and/or" conjunction creates three ADHD categories—combined type, predominantly inattentive type, predominantly hyperactive-impulsive type—different from DSM-III-R's single ADHD category.[43] But, in a slight modification from DSM-III-R language, "*some* of these behaviors were present before the age of seven"[44] (emphasis added). Finally, DSM-IV did not account for ratings of ADHD symptom severity.

DSM-5 modified the ADHD criteria with two key changes from DSM-IV-TR. First, although DSM-5 retained DSM-IV's three ADHD categories, DSM-5 changed the age criterion for the manifestation of "several" ADHD symptoms from "before the age of seven" to "were present prior to age 12 years."[45] Second, DSM-5 reinstituted DSM-III-R's mild, moderate, or severe severity rating of ADHD symptoms.[46] Furthermore, as in the DSM-III and DSM-IV editions, every behavioral criterion on which the child being assessed for ADHD is to be rated begins with, "Often … "—a recipe for imprecise assessments.[47] Two examples: "Often fails to give close attention to details or makes careless mistakes in schoolwork, at work, or during other activities"; "Often has difficulty organizing tasks and activities." Like other DSM-5 disorders, no definitive test or biological marker has been found to determine whether a child or an adult has ADHD. In fact, most children are given an ADHD diagnosis based merely on a teacher's complaint of inattention followed by a short visit to a pediatrician. At other times, the diagnostic process consists of no more than prescribing a medication for the child and telling the parents to observe if their child's behaviors and school performance improve.[48] Proper evaluation for ADHD is more comprehensive: it should involve an assessment by a mental health professional that includes interviews of the child and information from parents and teachers, often by means of standard questionnaires.

Not surprisingly, DSM-5 changes in the ADHD diagnosis are a major criticism of persons who sound the alarm of the risks and costs of overdiagnosing ADHD.[49] Critics point to the ADHD diagnostic criteria as evidence of the influence of pharmaceutical companies on DSM-5 decision-makers: profits for the drug companies that sell ADHD

42. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition–Text Revision 85 (2000) [hereinafter DSM-IV-TR].
43. *Id.* at 87.
44. *Id.* at 92.
45. DSM-5, at 60.
46. *Id.* at 60.
47. *Id.* at 59–60.
48. Maggie Koerth-Baker, *The Not-So-Hidden Cause Behind the ADHD Epidemic*, N.Y. Times, Oct. 15, 2013.
49. Batstra & Frances, *supra* note 37.

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medications have soared in the past 20 years.[50] In 2013, researchers from the Centers for Disease Control and Prevention released a study that examined the diagnosis of ADHD and medication of children with ADHD. The study concluded that the percentage of children with an ADHD diagnosis continues to increase, from 7.8 percent in 2003 to 9.5 percent in 2007 and to 11.0 percent in 2011. More than two-thirds of those with current ADHD were taking medication for treatment in 2011.[51] Note that this study's data predated DSM-5's May 2013 publication.

Asperger's Disorder. Asperger's disorder is another example of the difficulties of developing DSM-5 as a reliable and valid diagnostic system. In contrast to the ADHD diagnosis, which expanded the breadth of that category, Asperger's disorder, which first appeared in DSM-IV, was deleted as a separate diagnosis in DSM-5. Persons with DSM-IV-TR's Asperger's Disorder have severe difficulties understanding the conventions of back-and-forth social interactions, problems with eye contact during conversations, and trouble maintaining relationships.[52] In addition, these persons typically have narrow, fixated interests and activities.[53] Unlike autistic children's severe withdrawal from their environment, Asperger's disorder children, sometimes referred to as "high-functioning autism," are isolated because of their poor social skills and narrow interests.[54] The cause of Asperger's disorder is unknown; the course of Asperger's disorder is continuous and lifelong.[55] Diagnosis of Asperger's syndrome is complicated by the lack of a standardized diagnostic test.[56]

After much discussion, DSM-5's Task Force and the Neurodevelopmental Disorders Work Group decided to drop Asperger's disorder as a separate diagnosis and incorporate it instead into a new Autism Spectrum Disorder diagnosis. This new diagnosis includes the previous DSM-IV autistic disorder (autism), childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified.[57] DSM-5 developers concluded that the Autism Spectrum Disorder reflects a scientific consensus that four previously separate disorders, including Asperger's disorder, are actually a single condition with different levels of symptom severity.[58]

DSM-5 revisions to the diagnoses of autism and Asperger's disorder generated much controversy. Some argued that these major changes will result in loss of identity and of

50. Alan Schwarz, *The Selling of Attention Deficit Disorder*, N.Y. Times, Dec. 15, 2013.

51. Susanna N. Visser et al., *Trends in the Parent-Report of Health Care Provider-Diagnosed and Medicated ADHD: United States, 2003—2011*, J. Am. Acad. of Child & Adolescent Psychiatry (2013). Online: http://jaacap.org/webfiles/images/journals/jaac/visser.pdf (look in jaacap in 2013 o4 2014).

52. National Institutes of Health, *Asperger Syndrome Fact Sheet;* www.ninds.nih.gov—detail_asperger.htm

53. DSM-IV-TR, at 80.

54. NIH, *supra* note 52.

55. DSM-IV-TR, at 82.

56. NIH, *supra* note 52.

57. *Highlights of Changes from DSM-IV-TR to DSM-5;* http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf.

58. NIH, *supra* note 52.

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access to education and social services devoted to these diagnoses. How will insurance reimbursements be affected? Science? Politics? Who was "in the room" when these decisions were made?

Personality Disorders. Personality disorder diagnoses, particularly the dramatic ones—e.g., Borderline, Histrionic, Narcissistic—are often invoked in contentious family law cases as shortcut, dramatic labels to characterize a parent to the court. If the label, accurate or not, sticks, the parent is painted with a broad brush of negative behaviors that, it is claimed, will not readily change.

One problem with DSM-IV-TR personality disorder diagnoses is that their definitions conflated common lay usage with professional definitions. Popular books have claimed to help spouses deal with self-centered narcissists, moody borderlines, or manipulative sociopaths. Needless to say, the authors of these books readily stray from strict diagnostic criteria and guidelines as they describe personality disorder features and advise how to "diagnose" and manage personality disorders in other people.

Unfortunately, DSM-5 did not clarify these problems or other "numerous shortcomings" of the DSM-IV approach to personality disorders.[59] Intense disputes in the Personality and Personality Disorder Work Group over how to characterize personality disorders were among the most contentious in DSM-5's development. Disagreements centered on whether personality disorders should be described primarily as categories (this or that personality disorder—the DSM-IV approach) or as a dimensional system that measures degrees of impairments in personality functioning and pathological personality traits (a more precise, informative approach).[60] As noted earlier and as will be described later, the DSM acknowledges that describing diagnoses as categories raises questions about whether diagnoses have sufficiently defined boundaries to adequately distinguish diagnoses from each other. This problem is particularly true of personality disorders. For example, DSM-IV research suggests that pure, unmixed cases of disorders, particularly of personality disorders, are not representative of persons with the disorder, and that persons with "mixed" disorders differ from those with "pure" diagnoses.[61]

The disputes led DSM-5's Personality and Personality Disorder work group and Task Force to a key decision. The work group's alternative personality disorder model, a "hybrid" model that incorporated dimensional measures within personality categories, was deemed too radical a shift from DSM-IV's scheme.[62] Further, many clinicians found the alternative model difficult to apply easily—recall that a primary DSM-5 purpose is use by clinicians in

59. DSM-5, at 761.
60. DSM-5, at 762.
61. L.A. Clark, D. Watson, & S. Reynolds, *Diagnosis and Classification of Psychopathology: Challenges to the Current System and Future Directions*, 46 Ann. Rev. Psychol. 121, 126–33 (1995).
62. *See* Thomas A. Widiger, *Changes in the Conceptualization of Personality Disorder: The DSM-5 Debacle*, 41 Clinical Soc. Work J. 163 (2013).

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their offices and hospital work. As a result, the American Psychiatric Association's Board of Trustees decided to retain all of DSM-IV's categorical personality disorder diagnoses *in toto* in DSM-5. The proposed new model, *Alternative DSM-5 Model for Personality Disorders*, was relegated to DSM-5's *Section III—Emerging Measures and Models*, a section that lists proposals for future study.[63] At present, the alternative model is viewed as a "proposed research model," not to be used officially for psychiatric diagnosis.[64]

So, these three examples of diagnoses that may impact family law cases illustrate different diagnostic issues from the development of DSM-5, demonstrating the challenges inherent in devising a credible, reliable diagnostic scheme. The scope of the ADHD diagnosis was expanded from that of previous DSM editions, with little added specificity in its diagnostic criteria; Asperger's disorder was dropped in DSM-5 as a separate diagnosis and placed instead under the Autism Spectrum Disorder umbrella; DSM-IV-TR's personality disorder scheme was retained in DSM-5.

These examples also demonstrate the importance of considering the purpose for which DSM-5 diagnoses are used. A given reliability for a diagnosis, strong or weak, may be acceptable for a given use, depending on the purpose for using the diagnosis. For example, although a certain diagnosis may offer useful guidance for clinicians and researchers, that same diagnosis may not be sufficiently trustworthy (legal reliability) in court as a basis for "final and quick" legal decision-making.[65] This fact highlights DSM-5's cautions that its use in court carries "significant risks that diagnostic information will be misused and misunderstood," and that "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."[66] For example, regarding parenting-related decisions, statutes focus on evidence of parents' capacities to meet their children's needs; statutes do not identify any DSM-5 diagnosis as part of the analysis. Thus, a parent may be depressed, anxious, bipolar, or have a personality disorder, yet still fulfill legal requirements for adequate parenting.

We have looked at key issues in Topic One of our lawyer's approach to DSM-5: DSM-5's purposes, diagnostic limits, and development. Let's now explore Topic Two: The elements of a DSM-5 diagnosis.

Topic Two: The Elements of a DSM-5 Diagnosis

To effectively depose or examine experts who rely on DSM-5 diagnoses in their testimony, you must understand DSM-5's two-step diagnostic framework, detailed in Section

63. DSM-5, at 731.
64. *Id.* at 11.
65. *Daubert*, 509 U.S. at 597.
66. DSM-5, at 25.

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I of DSM-5, which describes how clinicians should determine what diagnosis to assign a patient. In addition, you should be aware of selected diagnostic issues that clinicians, and particularly experts, should account for.

The DSM-5 Diagnostic Two-Step

To determine what diagnosis to assign a patient, a clinician must answer two questions. First, a gateway question: Is there a mental disorder? If the clinician determines that the patient does not satisfy DSM-5's definition of a mental disorder, no diagnosis should be assigned.[67] If a mental disorder applies, a second question follows: What diagnosis identifies the nature of the mental disorder?

Although these two questions appear straightforward, DSM-5's definition of a mental disorder and its method for determining diagnoses are far from clear-cut. The mental health professional's clinical judgment—based in the professional's training, experience, and biases—is key to clarifying diagnostic ambiguities. This presents opportunities for lawyers to make experts clarify the bases of any diagnoses they invoke in their testimony. Let's break down DSM-5's two-step diagnostic framework.

First: Is There a Mental Disorder?

DSM-5 acknowledges that defining "mental disorder" is difficult; so many factors, including a culture's view of normal behavior and of accepted values, must be considered. Even if a person's behavior and values differ from the norm, such differences may not qualify as a mental disorder. In social science literature, definitions of mental disorder are quite elastic, although common, albeit imprecise, themes include distress, disability, dyscontrol, and dysfunction.[68]

DSM-5's definition of "Mental Disorder" requires that the patient experience clinically significant distress or disability in social, occupational, or other important activities.[69] Re-read this definition carefully. This definition provides an important threshold for determining a mental disorder, because persons for whom a diagnosis of "mental disorder" would be inappropriate may manifest behaviors that could be identified as DSM-5 symptoms, particularly in their milder forms.[70] For example, some people are quite

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67. DSM-5, at 20.

68. Frances & Widiger, *supra* note 5, at 7.3.

69. DSM-5, at 20. The DSM-5 definition of *mental disorder*: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above."

70. *Id*. at 21.

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detail-oriented, others more self-centered, others more emotionally expressive—traits that merely reflect human differences. Many clinicians will be unable to give the DSM-5 definition for a mental disorder. As a result, when asked for the definition on cross-examination, the "expert" may appear ill-prepared and not very expert at all.

Thus, DSM-5's diagnostic gateway requirement offers opportunities for lawyers. To flesh out a proposed diagnosis, break down the definition of *mental disorder* word by word:

- How does the expert define "clinically significant distress or disability"?
- How does the expert measure "clinically significant distress or disability" in the patient?
- How does the patient "experience clinically significant distress or disability" in social activities? In occupational activities? In other important activities?

Following these questions, ask the expert to articulate how his or her clinical judgment, informed by data, led to the decision about whether the patient has a mental disorder.

If the patient is deemed to be experiencing a DSM-5 defined mental disorder, the clinician then moves to the second step of DSM-5's diagnostic two-step.

Second: What Diagnosis Identifies the Nature of the Mental Disorder?

Clinicians determine DSM-5 diagnoses by comparing a patient's symptoms and complaints with listed criteria or symptoms associated with the various mental disorders—for example, depression or mood disorders, anxiety disorders, personality disorders. Each diagnosis designates the kind and number of criteria that a patient should meet before a certain diagnosis can be assigned.

Lawyers and mental health experts often treat DSM-5 diagnostic criteria as objective elements of checklists that must be satisfied. DSM-5 rejects this approach.[71] Rather, "diagnostic criteria are offered as guidelines." Clinical judgment is necessary when considering the contribution of diagnostic criteria to a diagnosis.[72]

How does DSM-5 define *clinical judgment*? Basically as "a product of clinical training and experience"[73]—certainly a critical skill, not to be minimized, in the clinician's office and an important factor, among others, to qualify an expert in court. DSM-5 states that clinical training is required "to recognize when the combination of predisposing, precipitating, perpetuating, and protective factors has resulted in a psychopathological condition in which physical signs and symptoms exceed normal ranges."[74] When the designated number of criteria are not met for a certain diagnosis, "clinicians should consider

71. *Id.* at 19.
72. *Id.*
73. *Id.* at 5; *see also id.* at 25 ("Use of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised").
74. *Id.* at 19.

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whether the symptom presentation meets criteria for an 'other specified' or 'unspecified' designation."[75] Further, a clinician may specify a provisional diagnosis when there is a "strong presumption" that the criteria for that diagnosis will eventually be met when the clinician considers more information.[76]

Clinical judgment is built into DSM-5's diagnostic process. To illustrate the point, consider the earlier discussion of the ADHD diagnostic criteria. Recall that every behavioral criterion on which the child being assessed for ADHD is to be rated begins with, "Often ..." Further, in the *Inattention* and *Hyperactivity and Impulsivity* sections of the criteria required for an ADHD diagnosis, six or more out of nine of these "often" criteria must apply in each section.[77] Why six criteria and not five? Although cut-off points to determine whether a person should be assigned an ADHD diagnosis are necessary to provide definition for clinical and research communication, those cut-offs are largely arbitrary.[78] For many diagnoses, the thresholds established for most of the DSM-IV-TR disorders were originally chosen as best guesses, presumably informed by research, arrived at by expert consensus.[79]

The critical takeaway for the second step of DSM-5's diagnostic two-step is that determining a diagnosis requires a balance of the clinician's professional judgment and the proper application of diagnostic criteria.[80] The heads of DSM-IV's Task Force characterized the balance well:

> 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]

Selected DSM-5 Diagnostic Issues

DSM-5 drew intense criticism during its development, some of which was based on its underlying approach to diagnoses and on its structure. Two issues are particularly important to consider: (1) the diagnosis as a surface-level definition; and (2) the difference between characterizing a diagnosis as a category or a dimension.

75. *Id.* at 19.
76. *Id.* at 23.
77. *Id.* at 59–60.
78. Frances, First, & Pincus, *supra* note 15, at 60.
79. *Id.*
80. DSM-5, at 21.
81. Frances, First, & Pincus, *supra* note 15, at 68.

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The DSM-5 Diagnosis: Just a Surface-Level Definition

Lawyers should understand that DSM-5 diagnoses are intended only as surface-level characterizations of a patient's mental disorder. A diagnosis does not address the deeper-level causes of the individual's mental disorder. For example, the ADHD diagnosis focuses on symptoms or behaviors (surface level) without reference to biological causes. The same is true for the various depression disorders, personality disorders, and substance use disorders. This issue is also highlighted when one notes that many diagnoses share symptoms. For example, anxiety appears in several DSM-5 diagnoses, just as sneezing is a physical symptom included in diagnoses of the flu, a cold, allergies, or just a brief nasal irritation.

The focus on symptom clusters to define a diagnosis, without tying those symptoms to biological markers or underlying causes, creates reliability and validity problems for DSM-5 diagnoses.[82] How can one be certain what the symptoms mean? DSM-5 notes that science is not mature enough "to provide consistent, strong, and objective scientific validators of individual DSM disorders,"[83] as it can with physical diseases such as lymphoma or ischemic heart disease.[84] DSM-5 acknowledges that we do not yet know enough to discern the validity of its diagnoses.[85] In addition, a DSM-5 diagnosis as a surface-level definition does not address the individual's degree of control over behaviors that may be associated with the disorder;[86] people with the same diagnosis may differ, for various reasons, in their abilities to control their behaviors.

Finally, DSM-5 is atheoretical. DSM-5 does not espouse a particular theory of mental disorders—not psychoanalytic, not behavioral, not physiological or medical.

In sum, a mental health professional's DSM-5 symptom-level diagnosis of a patient is, at best, a surface-level characterization of what a clinician determines to be a mental disorder. We can see symptoms and behaviors, but we cannot presume to know the causes of diagnoses to which those symptoms and behaviors are assigned.

Diagnostic Categories Versus Dimensions: Know the Difference

Lawyers should also appreciate problems inherent in DSM-5's use of categories for diagnoses. This seemingly abstract issue, noted in earlier discussion, is not difficult to understand and opens valuable lines of questions with which you can support or challenge experts' DSM-5-based testimony.

Similar to developers of past DSM editions, the DSM-5 work groups struggled with whether to characterize mental disorders as distinct categories or as conditions that lie along certain dimensions. Let's briefly look at diagnoses as categories and as dimensions.

82. *Id.* at 21.
83. *Id.* at 5.
84. Thomas Insel, *Director's Blog: Transforming Diagnosis* (Apr. 29, 2013), http://www.nimh.nih.gov/about/director/2013/transforming-diagnosis.shtml
85. DSM-5, at 5.
86. *Id.* at 25.

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Diagnoses as Categories. Viewing diagnoses as distinct categories says that the patient either has or does not have the diagnosis; a clinician decides whether the patient meets certain diagnostic criteria and then determines whether the disorder is present.[87] A clinician's diagnosis may be in error because of a clinician's faulty or biased judgments or because of imprecise diagnostic criteria; DSM-5 notes that boundaries between disorders are "more porous" than originally thought.[88] As a result, questions about classification errors—false positives (a positive diagnosis that is mistaken) and false negatives (a diagnosis was not made that should have been made)—arise.[89] DSM-5 acknowledges that focusing on the "present or absent" determination created "overly narrow" diagnoses "that did not capture clinical reality."[90] For example, is the diagnosis for major depression disorder so narrowly defined that some people who are truly depressed do not fit the diagnostic criteria (a false negative)? For lawyers concerned about evidentiary reliability, false positives and false negatives raise error-rate concerns (whether categorical diagnoses of mental disorders are sharply enough defined to accurately define who has the disorder or to accurately define who does not have the disorder)—a *Daubert*-related reliability consideration.[91]

ADHD and Borderline Personality Disorder illustrate the category issue for diagnoses. Regarding the ADHD diagnosis, discussed earlier, how much confidence can one have in a diagnosis whose symptom criteria each begin with "Often" and apply to behaviors seen in many children up to 12 years old?

Borderline Personality Disorder offers another example of the diagnosis as category problem. For example, of nine criteria that DSM-5 lists for the clinician to consider when deciding whether the Borderline Personality Disorder diagnosis applies to a patient, five or more criteria must apply to justify the diagnosis. Step back for a moment. This means that a clinician could diagnose two people with Borderline Personality Disorder who might share only one of the nine symptom criteria; that is, each person might reflect four symptom criteria that the other person does not reflect out of the five criteria required for the diagnosis. Further, some literature questions whether Borderline Personality Disorder could be more accurately classified among the mood disorders that include depression.[92]

DSM-5 tries to account for this imprecision problem. For example, DSM-IV-TR allowed a clinician to add "Not Otherwise Specified (NOS)" to a diagnosis when the patient's

87. W.E. Narrow & E.A. Kuhl, *Dimensional Approaches to Psychiatric Diagnosis in DSM-5*, J. Mental Health Pol'y Econ. 197 (2011).

88. DSM-5, at 6.

89. John A. Zervopoulos, How to Examine Mental Health Experts 126 (2013).

90. DSM-5, at 12.

91. *Daubert*, 509 U.S. at 593.

92. Antonia S. New, Joseph Triebwasser, & Dennis S. Charney, *The Case for Shifting Borderline Personality Disorder to Axis I*, 64 Biological Psychiatry 653 (2008); *see also* B.F. Grant et al., *Prevalence, Correlates, Disability, and Comorbidity of DSM-IV Borderline Personality Disorder: Results from the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions*, 69 J. Clinical Psychiatry 533 (2008) (at some point in their lives, 75% of people with BPD meet criteria for mood disorders, especially major depression and Bipolar I, and nearly 75% meet criteria for an anxiety disorder).

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symptoms "fell through the cracks" of the criteria requirements for a diagnosis,[93] a bow to the difficulties clinicians often encounter when determining patients' diagnoses. DSM-5 replaces NOS with two categories (*other specified disorder* and *unspecified disorder*) "to enhance diagnostic specificity" for the clinician and to provide the clinician an opportunity to explain why the patient's symptom presentation does not quite meet criteria requirements of the diagnosis.[94]

Diagnoses as Dimensions. Including dimensions in diagnoses—showing that the patient may have "a little more of this trait and a little less of another trait"—provides clinicians and researchers with more information than strict categorical diagnoses, allowing diagnoses to be nuanced to fit a particular patient's condition and responses to treatment.[95] For example, in one individual, a personality disorder may appear less severe or even seem "normal," while in another person that disorder could appear more severe and clearly pathological. ADHD, a category diagnosis, incorporates dimensional elements into its symptom criteria when it asks the clinician to specify the severity of the symptoms as mild, moderate, or severe. Substance Use Disorder, a new category in which the patient "continues using the substance despite significant substance-related problems," is assigned by range of severity of the disorder, "from mild to severe, with severity based on the number of symptom criteria endorsed."[96]

Despite the intentions of the Task Force and work groups, DSM-5 had difficulty more fully integrating dimensional measures into its diagnostic definitions. DSM-5 says that "despite the problem posed by categorical diagnoses, the DSM-5 Task Force, as noted earlier, recognized that it is premature scientifically to propose alternative definitions for most disorders."[97]

Summary of Topics One and Two: The Psychological Perspective

To this point, we have discussed Topic One (the purposes and development of DSM-5) and Topic Two (the elements of a DSM-5 diagnosis) of the lawyer's approach to DSM-5. These topics examined DSM-5 from the psychological perspective, based in social science. Before discussing Topic Three, the legal perspective's view based in evidence caselaw, let's summarize some of the key DSM-5 issues we have examined:

- DSM-5 was not developed for use in court. Although DSM-5 states that diagnoses and diagnostic information, when used appropriately, can assist in legal decision-making,

93. Frances, First, & Pincus, *supra* note 15, at 59.
94. DSM-5, at 15.
95. Narrow & Kuhl, *supra* note 87.
96. DSM-5, at 483–84.
97. *Id.* at 13.

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DSM-5 also cautions that "there is a risk that diagnostic information will be misused or misunderstood."[98] DSM-5 also notes that "the assignment of a particular diagnosis does not imply a specific level of impairment or disability."[99]

- A mental health professional's clinical judgment, based on experience and training, is a major component in determining whether a patient should be assigned a DSM-5 diagnosis.
- DSM-5 describes a two-step process for determining whether a diagnosis should be assigned. First: Is there a mental disorder? Second: If so, what type of mental disorder? To address if there is a mental disorder, DSM-5 proposes a "generic," nonobjective mental disorder threshold before a diagnosis is assigned: That the patient experiences a disturbance causing "clinically significant distress or disability in social, occupational, or other important activities."[100] To address the second step, the clinician must balance clinical judgment with consideration of diagnostic criteria listed for particular diagnoses under consideration.
- DSM-5 diagnoses describe only symptoms of proposed mental disorders, not underlying biological causes or theoretical (e.g., behavioral, psychoanalytic, medical) mechanisms.
- DSM-5 is primarily a categorical classification of separate disorders, although it includes dimensional ratings of the severity of some diagnoses.[101] That is, the patient is either assigned or not assigned to the disorder. The category approach opens DSM-5 diagnoses to classification errors (false positive or false negative diagnostic decisions) and thus questions about the accuracy of a given diagnosis for a given patient.

Topic Three: DSM-5, the Rules of Evidence, and Caselaw—The Legal Perspective

Topic Three of our lawyer's approach to DSM-5 addresses the legal perspective, derived from the rules of evidence and caselaw. The legal perspective alerts lawyers to caselaw-based tools with which to test the quality of DSM-5 testimony, whether at the admissibility stage or at trial, and to explain the strengths and shortcomings of that testimony to the court.

The Legal Backdrop

Admissible evidence must be relevant and reliable; this is the featured tenet in *Daubert*, also woven into the fabric of *Frye*.[102] *Daubert* views relevance, analyzed per Federal Rule

98. *Id.* at 25.
99. *Id.* at 25.
100. *Id.* at 21.
101. *Id.* at 13.
102. *Daubert*, 509 U.S. at 589.

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of Evidence 401, as a matter of "fit": whether the expert's testimony is sufficiently tied to the case facts to aid the jury in resolving the dispute.[103] "[F]it is not always obvious, and scientific validity for one purpose is not necessarily scientific validity for other, unrelated purposes."[104] The purpose for which experts assign DSM-5 diagnoses and use the diagnoses in their testimony is a key relevance question.

As noted in Chapter 3, reliable testimony equates to trustworthy testimony.[105] *Daubert*'s toolbox of factors, which include related factors noted in federal and state caselaw, help the trial judge test the quality of expert testimony and decide whether the testimony is sufficiently trustworthy to admit into evidence. Notably, social scientists use these same factors outside the courtroom to test the quality of each others' work. Thus, you should also use *Daubert* factors and reasoning as tools to assess the quality of already admitted testimony, to develop several lines of questions to explore that testimony, and to organize your legal arguments to the court.

Although the context of DSM-5–based testimony determines what *Daubert*-related factors apply in a given case, note how the following examples are particularly suited to critique DSM-5-based testimony:

- General acceptance in the mental health disciplines.[106] Is DSM-5 generally accepted among the mental health professions as an authoritative system for diagnosing mental disorders?
- Peer review and publication.[107] Has the development of DSM-5 and DSM-5 as a diagnostic system been sufficiently vetted in the mental health disciplines?
- The known or potential error rate of the particular technique.[108] How accurate are the expert's diagnoses? Has the expert allowed for errors of false positives and false negatives in the diagnoses on which the testimony is based?
- The extent to which the technique relies upon the subjective interpretation of the expert.[109] Does the expert overuse clinical judgment at the expense of utilizing diagnostic criteria when determining the diagnosis?
- The clarity with which the underlying scientific theory and technique can be explained to the court.[110] Does the expert clearly explain the data that support the invoked or assigned diagnosis, as well as the reasoning for applying the diagnosis?

103. *Id.* at 591.
104. *Id.*
105. *Id.* at 590 n.9.
106. *Daubert*, 509 U.S. at 594.
107. *Id.* at 593–94.
108. *Id.* at 594.
109. E.I. du Pont de Nemours & Co. v. Robinson, 923 S.W.2d 549, 557 (Tex. 1995).
110. Kelly v. State, 824 S.W.2d 568, 573 (Tex. Crim. App. 1992).

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- The nonjudicial uses that have been made of the theory or technique.[111] Would the expert apply the same diagnosis with the same reasoning and recommendations if the expert were assessing the case in a private practice setting instead of in a legal case?
- Whether the expert has considered alternate explanations of the data.[112] Did the expert consider reasonable alternative explanations of the data that might have led to a different diagnosis of the examinee?
- Whether the expert "employ[s] in the courtroom the same level of intellectual rigor that characterizes the practice of an expert in the relevant field."[113] Does the expert use the same or higher level of intellectual rigor when applying a DSM-5 diagnosis in the legal case as the expert uses in his or her clinical practice or research endeavors?
- The expert's experience and skill in the subject matter of the testimony.[114] Does the expert have sufficient experience, training, and skill to use DSM-5 properly?

At this point, we have addressed separately the psychological and legal perspectives of DSM-5 diagnoses. Our lawyer's approach thus far highlights a basic tenet of critiquing expert testimony of mental health professionals: Know the science that is the subject matter of the testimony (the psychological perspective), and know the law that applies (the legal perspective). Having separately addressed the psychological and legal perspectives of DSM-5 diagnoses, we have one more important step to take: to integrate information gained from each perspective.

Integrating the Psychological and Legal Perspectives

Integrating the psychological and legal perspectives of testimony based on DSM-5 diagnoses will sharpen your examinations of mental health experts and help you fashion compelling legal arguments. Organize your integration of the two perspectives around the legal concepts of relevance and reliability (trustworthiness).

As noted earlier, a key aspect of relevance is whether the evidence "fits" the case. Look to two issues to address the legal relevance question. First is the purpose underlying the expert's use of the diagnosis. For example, if the expert testifies that mother is diagnosed with a Major Depressive Disorder and may benefit from counseling and medication—treatments that could benefit her well-being and, presumably, her parenting—that testimony appears to fit the clinical and treatment planning purposes for DSM-5's development and use. However, if the expert testifies that mother is an inadequate parent because she

111. *Robinson*, 923 S.W.2d at 557.
112. Fed. R. Evid. 702 (advisory committee note, 2000 amendment).
113. Kumho Tire Co. v. Carmichael, 526 U.S. 137, 152 (1999).
114. *Id.* at 156; *Kelly*, 824 S.W.2d at 573.

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has been diagnosed with Major Depressive Disorder, this would be a misuse of DSM-5. Neither DSM-5 nor family code statutes identify any DSM-5 diagnosis as a criterion for sufficient parenting that would meet the best interest of the child.

In the preceding example, DSM-5 testimony becomes most relevant when its purpose is to inform a functionally oriented approach that describes the parent-child relationship by focusing on parents' identified abilities, impairments, and capacities to meet their children's identified needs. Indeed, family law statutes and caselaw involving parents and children concern themselves with impairment or capacity without regard to a DSM-5 diagnosis.[115] For example, a child with conduct problems may benefit most from a parent who values structure, whereas an emotionally reserved child might do better with a creative and affirming parent; diagnoses do not speak directly to these functional concerns.[116] A parent with a DSM-5 disorder may still be able to meet a child's needs.[117]

The *Model Standards of Practice for Child Custody Evaluation* of the Association of Family and Conciliation Courts highlights the point:

> Evaluators recognize that the use of diagnostic labels can divert attention from the focus of the evaluation (namely, the functional abilities of the litigants whose disputes are before the court) and that such labels are often more prejudicial than probative. For these reasons, evaluators shall give careful consideration to the inclusion of diagnostic labels in their reports. In evaluating a litigant, where significant deficiencies are noted, evaluators shall specify the manner in which the noted deficiencies bear upon the issues before the court.[118]

DSM-5 highlights this point as well. In its *Cautionary Statement for Forensic Use of DSM-5*, DSM-5 notes that "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."[119]

In sum, DSM-5 diagnoses are relevant only for the purpose of informing the functional analysis of parent-child relationships (how those relationships work), not for the purpose of defining those relationships.

Reliability, or trustworthiness, is the second legal concept with which to organize your integration of the psychological and legal perspectives. As noted earlier, *Daubert*-related tools, many of which were listed earlier, offer ways to integrate our two perspectives.

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115. Stuart A. Greenberg, Daniel W. Shuman, & Robert G. Meyer, *Unmasking Forensic Diagnosis,* 27 Int'l J.L. & Psychiatry 1, 1 (2004).

116. *Id.* at 1.

117. *Id.* at 12.

118. Association of Family and Conciliation Courts, *Model Standards of Practice for Child Custody Evaluation*, 45 Fam. Ct. Rev. 70, 78 (Std. 4.6(c)) (2007).

119. DSM-5, at 25.

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Build the skeleton of your arguments with the factors and flesh out the skeleton with the psychological perspective. Let's look at how this works to support or to challenge DSM-5-based testimony.

Arguments for Admissibility or Use of DSM-5 Based Testimony

General acceptance and peer review and publication are strong arguments to support the use of DSM-5 testimony. These are traditional reliability indices to which courts readily refer when testing the trustworthiness of expert testimony.[120]

General Acceptance Among Mental Health Professionals

The DSM system has, for many years, been the primary diagnostic classification system for mental disorders used by mental health professionals in the United States. Despite some heated controversy that attended the launch of DSM-5 in 2013, it is expected that mental health professionals will continue to use DSM-5 to make diagnoses and develop treatment plans, to conduct research, and to serve as a compendium of accepted mental disorders.

Some mental health professionals argue that the World Health Organization's ICD-9 and ICD-10 versions are well on their way to supplanting DSM-5. Although, as noted earlier, ICD-9-CM is the HIPAA-approved coding system for classifying mental disorders in the United States (ICD-10-CM is scheduled to be implemented in the United States in late 2015 for all U.S. health care providers and systems), DSM-5 is largely compatible with the ICD-10-CM classification system. DSM-5 lists the ICD-9 and ICD-10-CM number codes for most of its listed disorders. DSM-5 claims that forthcoming ICD-11 codes are expected to reflect similar correspondence with DSM-5.[121]

Peer Review and Publication

Peer review is a profession's vetting process for testing the quality of its ideas and writings. Usually, peer review is conducted through the profession's publication process, though not all publication-oriented peer review is equally rigorous; some journals are easier to publish in than others. Even *Daubert* notes that publication does not necessarily correlate with reliability.[122]

To use *Daubert*'s peer review factor to support admissibility of DSM-5 testimony, define peer review as a vetting process. The development of DSM-5 reflects several impressive vetting layers. Several hundred mental health professionals purported to rely on available empirical and clinical research literature when deciding what diagnoses to include and what criteria should determine those diagnoses. A Task Force of 31 mental health

120. Veronica B. Dahir et al., *Judicial Application of* Daubert *to Psychological Syndrome and Profile Evidence*, 11 Psychol. Pub. Pol'y & L. 62, 75 (2005).
121. DSM-5, at 11.
122. *Daubert*, 509 U.S. at 593.

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professionals, mostly psychiatrists, directed the DSM-5 project. Experts in 13 work groups, which represented various diagnostic areas, reviewed diagnoses from previous DSM editions and proposed changes to those diagnoses that they deemed necessary. More than 400 additional nonvoting work group advisors also participated in the process.[123] Proposed DSM-5 provisions were actively debated. Final decisions were made by the Task Force and by the American Psychiatric Association's Board of Directors.

Arguments Against Admissibility or Use of DSM-5 Diagnosis-Based Testimony

As noted throughout this chapter, the DSM-5 manual acknowledges that diagnoses do not represent bright-line categories, and the process by which mental health professionals determine diagnoses depends heavily on the professional's clinical judgment. Add to these issues DSM-5's broad, abstract definition of "mental disorder." You can explore these important issues with the expert using *Daubert*-related tools. Again, the key reliability question is: Can the court trust the testimony?

The Known or Potential Error Rate of the Particular Technique

As noted earlier, classification errors give rise to error-rate problems, a key *Daubert* factor to consider when determining whether the clinician placed the patient in the proper diagnostic class or category. Don't get lost in the statistics or numbers in which discussion of error rate is often couched. Instead, highlight the principles. DSM-5's description of the process of diagnosing patients opens the door wide to error-rate arguments in court. When dealing with whether the clinician gave the proper DSM-5 diagnoses, focus on two classification concepts: the consequences and the contexts of classification errors.

First, the consequences. Different consequences flow from two types of classification errors: false positives (mistaken diagnoses or classifications) and false negatives (diagnoses of classifications not made that should have been made). Most testifying experts who invoke DSM-5 will describe examinees as having or not having certain diagnoses. This is when your error-rate antennae should be alerted.

Consider building your arguments with the following ideas that highlight possible error-rate problems (false positives or false negatives) inherent in DSM-5's categorical approach to diagnoses:

- "DSM is a medical classification (i.e., in-or-out) of disorders."[124]
- Mental disorders are not distinguished by clear "in-or-out" diagnostic boundaries.[125]
- Patients with the same diagnosis may present differently to clinicians.[126]

123. DSM-5, at 7.
124. DSM-5, at 10.
125. Frances, First, & Pincus, *supra* note 15, at 19.
126. *Id.*

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- "Many symptoms assigned to a single disorder may occur, at varying levels of severity, in other disorders."[127]
- The specific number of symptoms required to determine many diagnoses was set arbitrarily in the DSM-5 development process.

Second, the contexts. Because error is inherent in all classifications, the trial judge will consider the context of the evidence offered when determining whether to exclude testimony on the basis of error-rate concerns. For example, a court may admit testimony relying on a psychological test that has a high probability of misclassifying a parent as having a borderline personality disorder but reject testimony relying on a drug test that frequently misclassifies a "clean" parent as a "user." The consequences of classification error in the latter scenario are more serious than in the former scenario.

The Extent to Which the Technique Relies Upon the Subjective Interpretation of the Expert[128]

This *Daubert*-related factor from a Texas Supreme Court case may address the process by which an expert determines a DSM-5 diagnosis. Determining a diagnosis relies on the mental health professional's or expert's clinical judgment, developed by knowledge and training, not on identification of specific biological markers from medical tests. Although the expert's dependence on clinical judgment when using DSM-5 may meet the needs of the expert's outside-the-court clinical practice, is such an approach adequate for courtroom testimony? If so, how much knowledge and training is sufficient to qualify an expert to invoke DSM-5 in testimony? How much "subjective interpretation" fills in the blanks in the reasoning that the expert used to determine the diagnosis?

The following DSM-5 issues address this factor:

- "Mental disorder" is not objectively defined.
- The manifestation of a "mental disorder"—that there be clinically significant distress or disability in social, occupational, or other important activities—also is not objectively defined. Yet DSM-5 requires this definition as a "generic" threshold for any DSM-5 diagnosis.[129] Without this manifestation—a gateway, predicate condition—a diagnosis is unjustified.[130]
- DSM-5 notes that diagnostic criteria identifying the types of mental disorders are guidelines for making diagnoses, and are not to be applied rigidly or mechanically.[131]

127. DSM-5, at 5.
128. *Robinson*, 923 S.W. 2d at 557.
129. DSM-5, at 21.
130. *Id.*
131. *Id.*

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- Without objective definitions of a mental disorder, its manifestation, or its identification, DSM-5 states that the clinician must exercise clinical judgment, the product of clinical training and experience, when determining whether a mental disorder exists and in what form (diagnosis) it manifests itself.[132]

The Clarity with Which the Underlying Scientific Theory and Technique Can Be Explained to the Court[133]

The clarity factor, noted in a Texas Criminal Court of Appeals case, makes sense. If an expert cannot clearly explain the reasoning behind the determination of a DSM-5 diagnosis, how can the court determine whether the testimony is reliable? Mental health experts who use DSM-5 to support their testimony may pepper their opinions with arcane terms—ego defense mechanisms, trauma reactions, narcissistic injury—and often have difficulty clearly explaining how the assigned diagnosis affects the examinee's daily life. Don't settle for jargon or for the broad generalizations that experts often use when their testimony centers on DSM-5 terms and diagnoses. Remember, testimony, in *Frye* and *Daubert* jurisdictions, that is deemed "understandable" merely because of the expert's word or qualifications should trigger questions about the testimony's reliability: "It is not so simply because an expert says it is so."[134]

The Nonjudicial Uses That Have Been Made of the Theory or Technique[135]

This factor, also from a Texas Supreme Court case, speaks to experts who use theories or techniques that they have devised or adapted solely for litigation to support their testimony—theories or techniques not otherwise used in the daily practice of the discipline. Consider the following questions:

- Did the expert apply the diagnosis in a novel way to fit the litigation?
- Did the expert make up a diagnosis and attempt to give it credence by appealing to his or her status as a psychiatrist or psychologist?
- Is the expert aware of DSM-5's *Cautionary Statement for Forensic Use of DSM-5,* which warns of the risk that DSM-5 diagnostic information could be misused or misunderstood?

Whether the Expert Has Considered Alternate Explanations of the Data[136]

This *Daubert*-related factor addresses whether the expert approached the diagnostic task in an open-minded manner that considered reasonable alternative explanations of case

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132. DSM-5, at 5; *see also id.* at 25 ("Use of DSM-5 to assess for the presence of a mental disorder by nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised").
133. *Kelly*, 824 S.W.2d at 573.
134. Gammill v. Jack Williams Chevrolet, Inc., 972 S.W.2d 713, 726 (Tex. 1998).
135. *Robinson*, 923 S.W.2d at 557.
136. Fed. R. Evid. 702 (advisory committee note, 2000 Amendment).

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data or information. This factor is also an important tenet in science: Investigations that do not consider reasonable alternative explanations of the data are vulnerable to confirmatory bias (locking into conclusions before the data have been sufficiently considered).

- How actively did the expert consider reasonable alternative explanations of the data that might have led to a different diagnosis of the examinee?
- What other diagnoses did the expert consider, and on what basis did the expert reject those diagnoses?

Summary: Understanding DSM-5—A Lawyer's Approach

Although DSM-5 states that diagnoses and diagnostic information can assist legal decision-making, DSM-5 also cautions that diagnostic information can be "misused and misunderstood" in the courtroom.[137] DSM-5 was not developed to be used in legal cases.

DSM-5 diagnoses in family law are not substitutes for describing an adult's or a child's behaviors. Additional information from a mental health expert—centering on the adult's or child's strengths, impairments, and abilities that may vary widely within each diagnostic category—is required to properly assist the court.[138]

To understand and critique a mental health expert's use of DSM-5 diagnoses, don't begin by wrestling with the expert over details of assigned diagnoses; retain a board-certified forensic psychiatrist (ABPN) or a board-certified forensic psychologist (ABPP) to educate you about the literature and research that supports assigned diagnoses. Instead, make experts support their diagnosis-based testimony by applying the analysis used throughout this book for confronting mental health testimony.

Our analysis centers on developing the psychological and the legal perspectives of DSM-5-based testimony. The process: First, separately flesh out the psychological and legal perspectives, and then integrate each perspective's information to sharpen your deposition and examination questions and to fashion compelling arguments to the court.

We discussed three key topics that develop the psychological and legal perspectives for testimony that invokes DSM-5 diagnoses. The first two topics—*Purposes and Development of DSM-5*, and the *Elements of a DSM-5 Diagnosis*—address the psychological perspective in relation to DSM-5 and psychiatric and psychological literature. The third topic—*DSM-5, the Rules of Evidence, and Caselaw*—addresses the legal perspective by casting *Daubert*-related factors as tools that lawyers can use to critique experts' uses of DSM-5 diagnoses; social scientists use these same factors outside the courtroom to critique

137. DSM-5, at 25.
138. *Id.*

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each other's work. As we addressed each topic, we fulfilled the demand to flesh out the psychological and legal perspectives separately. Then we closed the chapter by integrating the two perspectives, offering approaches to support or object to the admissibility or use of DSM-5 diagnosis-based testimony.

For lawyers, the bottom-line question for DSM-5-based testimony is the same as for any other expert testimony: Can the court trust the testimony? To answer that question, require mental health experts to answer the basic question of experts that threads through this book: "How do you know what you say you know?"