DSM-5
WHAT YOU NEED TO KNOW ABOUT WHAT'S OLD AND WHAT'S NEW

AAML-New York Chapter CLE
May 2, 2014

Allan M. Lans, D.O.
155 East 55th Street
Suite 6B
New York, New York 10022
(212) 759-5041
DrAllan.Lans@verizon.net

Lawrence Jay Braunstein, Esq.
Braunstein & Zuckerman, Esqs.
123 Main Street, 17th Floor
White Plains, New York 10601
(914) 997-6220
ljbraunstein@bzesqs.com

I. Historical Perspective of the Relationship Between the Legal System and Mental Illness

1581- Edward II stated that under English Common Law if the defendant in a criminal case had no more understanding than a "wild beast", they should not be held responsible for the crime committed.

The British Courts of the 18th century refined the "wild beast" test by stating that if a defendant lack sanity to the extent that he understood the ramifications of his behavior "no more than an infant, a brute, or a wild beast" he would not be responsible for his crimes.

In 1838 an American Psychiatrist, Dr. Isaac Ray, published a book entitled "*A Treatise on the Medical Jurisprudence of Insanity*".

The standard continued until 1843 when the M'Naghten case was tried in England. Daniel M'Naghten, believing he was being persecuted by Tories, sought to assassinate the Prime Minister, Robert Peel. He misidentified his target and inadvertently shot and killed the Prime Minister's secretary, Edward Drummond. M'Naghten pleaded not guilty. Witnesses testified as to his mental state at trial and he was found not guilty on the grounds of insanity.

Queen Victoria was outraged by the verdict, since she and her husband, Prince Albert, had been the target of assassination attempts. At the Queen's request, and as a result of considerable public pressure, a panel of learned jurists addressed the defense and created the M'Naghten Rule, which states,

"…to establish a defense on the ground of insanity, it must be clearly proved that, at the time of the committing of the act, the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing; or, if he did know it, that he did not know he was doing what was wrong."

The M'Naghten test set aside the subjective experience of the mentally ill defendant and substituted a cognitive test. By 1851 courts in the United States adopted it as a standard for determining legal sanity.

What appears to be the first official attempt to gather information about mental health in the United States was the recording of the frequency of "idiocy/insanity" in the 1840 census.

In 1875 the New York Domestic Relations Law dealing with annulments stated that

> "A marriage contracted by a person of unsound mind is voidable…The statute recognizes two forms of mental incapacity:
>
> > (1) Idiocy, or congenital mental defect which is necessarily permanent;
> > (2) Lunacy, or loss of original mental capacity caused by disease, which loss may be temporary or permanent

By the 1880 census seven categories of mental health were distinguished: mania, melancholia, monomania, paresis, dementia, dipsomania and epilepsy.

In 1917 a Statistical Manual for the Use of Institutions for the Insane was created, listing 22 diagnoses, followed by the Standard Classified Nomenclature of Disease in 1942 and the Armed Forces Nomenclature in 1943.

In 1949 the World Health Organization and the International Classification of Diseases (ICD) were established.

The DSM-I was published in 1952 and listed 106 mental disorders, followed by the DSM-II in 1968 (182 disorders); DSM-III in 1980 (265 disorders) and DSM-III-R in 1984 (292 disorders); DSM-IV in 1994 (297 disorders) and DSM-IV-TR in 2000.

The DSM-5 (no more Roman numerals) was released in May 2013.

II. The DSM-5

According to the American Psychiatric Association, the "DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders."

The DSM-5 is a culmination of a 14 year revision process. Dr. Gordon Cochrane, in his article entitled "The DSM-V [sic] and the Law: When Hard Science Meets Soft Science in Psychology" in the June 2013 edition of the *New York State Bar Journal*, wrote,

> …[A]ttorneys will best serve their clients when they view the DSM-V [sic] disorders and their symptom clusters through a lens of respectful skepticism. Psychology and psychiatry are more soft science than hard science, so there are few absolutes. Whereas much in psychology and psychiatry is acceptably validated by research, much is theory based and much is opinion based. Therefore, insist on the use of everyday English to explain psychological terminology that may not rest on solid research-validated foundation that the specialized terms imply. It is appropriate, and usually beneficial to your client, that, when reviewing a medical-legal report, in interacting with opposing counsel or during cross-examination, you ask for clarification of the type of evidence that supports the psychology or psychiatry evidence being proposed.
>
> The DSM-V [sic] is a valuable and necessary document but when its contents become a potentially influential factor in your cases, its limitations need to be identified and, when necessary, respectfully but rigorously challenged.

DSM-5 Cautionary Statement:

"Although the DSM-5 diagnostic criteria and text are primarily designed to assist clinicians in conducting clinical assessment, case formulation, and treatment planning, DSM-5 is also used as a reference for the courts and attorneys in assessing the forensic consequences of mental disorders. As a result, it is important to note that the definition of mental disorder included in DSM-5 was developed to meet the needs of clinicians, public health professionals, and research investigators rather than all of the technical needs of the courts and legal professionals…

When used appropriately, diagnoses and diagnostic information can assist legal decision makers in their determinations…

By providing a compendium based on a review of the pertinent clinical and research literature, DSM-5 may facilitate legal decision makers' understanding of the relevant characteristics of mental disorders…

However, the use of DSM-5 should be informed by an awareness of the risks and limitations of its use in forensic settings. When the DSM-5 categories, criteria, and textual descriptions are employed for forensic purposes, there is a risk that diagnostic information will be misused or misunderstood.

These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. In most situations, the clinical diagnosis of a DSM-5 mental disorder…does not imply that an individual with such a condition meets legal criteria for the presence of a mental disorder or a specified legal standard (e.g., for competence, criminal responsibility, or disability). For the latter, additional information is usually required beyond that contained in the DSM-5 diagnosis, which might include information about the individual's functional impairments and how these impairments affect the particular abilities in question. 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."

DSM-5 and the Practice of Family and Matrimonial Law - What's New?

1. Elimination of Multiaxial Assessment

The "old":

Axis I-	Clinical Disorders
Axis II-	Personality Disorders and Mental Retardation
Axis III-	General Medical Conditions
Axis IV-	Psychosocial and Environmental Problems
Axis V-	Global Assessment of Functioning

2. Personality Disorders (645)

"A personality disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment."

There are 10 distinct types:

Paranoid personality disorder
Schizoid personality disorder
Schizotypal personality disorder
Antisocial personality disorder
Borderline personality disorder
Histrionic personality disorder
Narcissistic personality disorder
Avoidant personality disorder
Dependent personality disorder
Obsessive-Compulsive personality disorder

The DSM-5 has a section entitled "Section III-Alternative DSM-5 Model for Personality Disorders" (761) which suggests an alternative model to assess personality disorders by characterizing them "…by impairments in personality *functioning* and pathological personality *traits*. The specific personality disorder diagnoses that may be derived from this model include antisocial, avoidant, borderline, narcissistic, obsessive-compulsive, and schizotypal personality disorders.

3. Parent-Child Relational Problem (715)

This is the closest that the DSM-5 has gotten in recognizing the issue of parental alienation.

"Cognitive problems may include negative attributions of the other's intentions, hostility toward or scapegoating of the other, and unwarranted feelings of estrangement."

4. Child Affected by Parental Relationship Distress (716)

"This category should be used when the focus of clinical attention is the negative effects of parental relationship discord (e.g., high levels of conflict, distress, or disparagement) on a child in the family, including the effects on the child's mental or other medical disorders."

5. Child Psychological Abuse (719)

"Child psychological abuse is nonaccidental verbal or symbolic acts by a child's parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child."

6. Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder (50)

"The revised diagnosis represents a new, more accurate, and medically and scientifically useful way of diagnosing individuals with autism-related disorders."

7. Streamlined classification of bipolar and depressive disorders

8. <u>Section III- Conditions for Further Study</u> (783)- This is a new section to highlight disorders that require further study but are not sufficiently well established to be part of the official classification of mental disorders for routine clinical use:

For example:

Caffeine Use Disorder (792)
Internet Gaming Disorder (795)
Nonsuicidal Self-Injury (intentional self-inflicted injury, e.g. cutting) (803)

9. <u>Section on Cultural Formulation</u> (749)

Cultural syndrome
Cultural idiom
Cultural explanation or perceived cause

"The Cultural Formulation Interview (CFI) is a set of 16 questions that clinicians may use to obtain information during a mental health assessment about the impact of culture on key aspects of an individual's clinical presentation and care." (750)

10. <u>Discontinuation of the term "mental retardation" to be replaced with "intellectual developmental disorder</u>

11. <u>Factitious Disorder Imposed on Another</u> (Previously Factitious Disorder by Proxy)

12. <u>Attention Deficit/Hyperactivity Disorder</u> (59)

The definition of ADHD has been updated to more accurately characterize the experience of affected adults.

"While the criteria have not changed from DSM-IV, examples have been included to illustrate the types of behavior children, older adolescence, and adults with ADHD might exhibit. The descriptions will help clinicians better identify typical ADHD symptoms at each stage of patients' lives."

A list of Highlights of Changes from DSM-IV-TR to DSM-5 can be found at
http://www.dsm5.org/Documents/changes%20from%20dsm-iv-tr%20to%20dsm-5.pdf