Introduction to the Special Section on DSM-5 and Forensic Psychiatry

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The American Psychiatric Association's (APA) 2013 publication of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5),[1] marks the first substantial revision of the psychiatric diagnostic classification system since the publication of DSM-III in 1980.[2] In recent decades, significant advances in behavioral science, neuropsychiatry, molecular genetics, neuroimaging, and other fields of research have added new and important information to the understanding of mental disorders. The DSM-5 Task Force comprised work groups of clinicians, researchers, statisticians, and others who aspired to improve the validity of mental disorder diagnoses by incorporating information from empirical studies published over the past two decades into the diagnostic schema.

In this Special Section of The *Journal*, changes in the DSM-5 of particular importance to forensic psychiatrists are examined and discussed. The authors will present and discuss information relevant to the development of DSM-5, including its use in forensic practice, changes in the classification of specific disorders and the assessment of functioning, the end of the categorical multiaxial diagnostic system, and how transitioning to a dimensional diagnostic model may affect diagnosis and the determination of impairment. Some of these changes have been the source of criticism and conflict within the field of psychiatry.

Classification is the core of any science, and therefore debate and controversy inevitably accompany the process of change. The desire to advance a science is only one of the many influences that play a role in the development of any classification system. Consequently, the roll-out of DSM-5 has revived older political, social, and scientific debates and criticism of the APA's official classification of mental disorders and, in addition, has created new areas of controversy.

The implications of the changes in DSM-5 of psychiatric diagnostic classifications and methodology for the practice of forensic psychiatry merit keen scrutiny. Forensic psychiatrists should be prepared to address both the uses and the limitations of psychiatric diagnoses in forensic practice. Psychiatric testimony, including opinions regarding psychiatric diagnoses, enters administrative, bureaucratic, and legal systems for a variety of reasons, ranging from testimony during the sentencing phase in capital murder trials to assessment of eligibility for disability benefits.

Psychiatric disorders are often threshold requirements to meet specific legal sanctions or administrative determinations. Mental disorders generally serve these threshold functions because they are believed to be meaningfully associated with diminished abilities or functional impairments. Even when not required, psychiatric diagnoses may be sought or requested because they lend credibility to legal arguments or administrative claims.

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Forensic psychiatrists are therefore well advised to familiarize themselves with the changes in the diagnostic system and process incorporated in DSM-5. The DSM is often mischaracterized in court and by the popular press as the Bible of mental health professionals. Deviating from its contents can cast doubt on the expert's scientific credibility. Although the DSM has always been a reference for and a guide to psychiatric diagnostic classification, and not a bible, the problems of using a classification system for purposes other than those for which it was intended have been clear for some time.

The editors of DSM-5, like those of previous editions, have clearly indicated that the classification system's primary goal is "first and foremost to be a useful guide to clinical practice" (Ref. 1, p xli). The goals of psychiatric evaluations conducted for clinical treatment and research differ from those conducted for forensic purposes; the methodology of each type of evaluation is subject to different standards and ethics, as well. Moreover, psychiatric diagnoses cannot of themselves establish any legally significant findings regarding the past or present mental state of an individual or the degree of responsibility for his behavior.

This is the "imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis" (Ref. 1, p 25) to which the DSM refers. The imperfect fit has been and continues to be the subject of much discussion and debate in the field of forensic psychiatry. Numerous books, articles, and presentations have considered the challenges of using the principles of psychiatric evaluation and diagnosis in forensic settings. Some of the boundaries at the interface of law and psychiatry are also often a core concern in challenging courtroom cross-examination. It has become clearly apparent, sometimes painfully so, that even minor changes in the wording of the DSM's diagnostic criteria and accompanying text can have unforeseen legal and administrative consequences.

Developing DSM-5

In 1980, DSM-III revolutionized how psychiatrists conceptualized mental disorders. It introduced specific criteria, based as much as possible on empirical evidence that standardized the classification of mental disorders and improved the reliability of diagnostic evaluation. The publication of DSM-III represented a paradigm shift in psychiatry and reflected the increasing influence of biological psychiatry in a field long dominated by psychoanalytic and psychodynamic principles, even in classification of mental disorders.

DSM-III has undergone additional revisions, resulting in the publication of DSM-III-R,[3] DSM-IV,[4] and DSM-IV-TR.[5] These subsequent editions did not encompass major conceptual changes. They continued to emphasize a structured approach to the diagnosis of mental disorders, with increasing consideration of impairment as one of its core elements. Forensic psychiatry benefitted from the emphasis because impairment, rather than diagnosis, was often the crux of a forensic psychiatric evaluation.

Forensic Psychiatry and DSM-5

The DSM-5 Task Force was aware that forensic psychiatrists would bring different and important perspectives to the consideration of changes in diagnostic classification and evaluation. For the first time in the history of the DSM, members of the APA's Council on Psychiatry and the Law were invited to serve as Forensic Advisors to the DSM-5 Work Groups. The Advisors' role was to alert work group members to anticipated problems associated with the use of the proposed diagnostic criteria in nonclinical settings and to identify pitfalls that could be created by the proposed revisions. By the time DSM-5 was published, the proposed revisions had undergone multiple changes and had been subjected to field trials, community feedback, and review by forensic advisors.

One result of the participation of members of the Council of Psychiatry and Law in the revision process was the "Cautionary Statement for Forensic Use of DSM-5" (Ref. 1, p 25), a significant expansion of the Cautionary Statement in prior editions. While acknowledging the DSM's use as a reference by the courts and legal professionals, this statement indicates that DSM-5 is not a resource designed to meet "all of the technical needs" of the legal system (Ref. 1, p 25).

Forensic psychiatrists should be aware of the limitations of DSM-5 in forensic settings as stated in the Cautionary Statement, should endeavor to educate legal professionals and others about these limitations, and should warn others when these limitations have been ignored. The Cautionary Statement clearly indicates that although DSM-5 can be helpful, its use in forensic settings presents the risk that diagnostic

information will be "misused or misunderstood" because of the "imperfect fit between questions of ultimate concern to the law and the information contained in a clinical diagnosis" (Ref. 1, p 25).

The Cautionary Statement also admonishes that the use of the DSM by "nonclinical, nonmedical, or otherwise insufficiently trained individuals is not advised" (Ref. 1, p 25). Forensic psychiatrists are often in a position to clarify the need for clinical expertise in the use of the DSM. Many legal professionals also mischaracterize the DSM as a sort of cookbook, implying that anyone can follow the recipes to make or disprove a psychiatric diagnosis. That clinical training and experience are essential to the effective and appropriate application of the DSM cannot be overemphasized.

Nevertheless, the Cautionary Statement is a generic warning. Forensic psychiatrists should also carefully consider what new benefits, risks, and problems the changes in DSM-5 have created regarding specific diagnoses and forensic evaluations. New features include, among others:

- A transition from a categorical to a dimensional system of diagnosis, and with this, abandonment of the multiaxial system of diagnosis
- The replacement of the label, not otherwise specified, with the labels, other specified disorder and unspecified disorder
- The increased harmonization of the DSM diagnostic system with that of the International Classification of Disease (ICD) of the World Health Organization (WHO) and the use of a new coding structure
- The reorganization of diagnostic classification to reflect developmental and lifespan considerations
- The expansion of information regarding gender and cultural considerations in diagnosis
- The emergence of major conceptual changes in certain diagnoses and diagnostic categories, reflecting the incorporation of empirical research findings

Changes have been made in the previous system of diagnostic classification and methodology to such an extent that it is impossible to examine them all in a single *Journal* issue. Not all of the changes have implications for the practice of forensic psychiatry. We have chosen to include articles that explore the areas forensic psychiatrists are more likely to encounter, including some that have undergone significant change and some that are more controversial.

Paul Appelbaum, MD, describes his role and the role of forensic psychiatry in the DSM-5 development process. He was instrumental in advocating for incorporating forensic considerations into the new edition. He participated in the executive Summit Committee meeting, during which feedback from the committees and Work Group chairs regarding the proposed draft of DSM-5 were consolidated before review by the APA Assembly and Board of Trustees executive committees. He also authored the expanded Cautionary Statement, and is involved in developing the process by which the DSM will be updated.

Two articles in this Special Section address concerns regarding the exclusion of the multiaxial system of psychiatric diagnosis. This change, which brings the DSM into closer alignment with the structure of the ICD, will affect forensic psychiatrists who will have to explain to courts, corrections officials, and others what has happened to Axis II and III diagnoses. Robert L. Trestman, PhD, MD, examines the effect of this change on the classification of the personality disorders. Liza H. Gold, MD, discusses the implications of the removal of Axis V and the Global Assessment of Functioning Scale and the tentative substitution of the WHO Disability Assessment Schedule 2.0 (WHODAS 2.0) for the assessment of impairment and disability.

Some psychiatric illnesses, such as psychotic and affective spectrum disorders, are more frequently encountered in forensic settings than in others. George F. Parker, MD, considers the changes in the classification of the psychotic and affective spectrum disorders, including the new dimensional assessment schema, new diagnoses, and the revised nomenclature for the affective disorders.

Some of the most substantial and controversial changes, including a revised definition of trauma, involve the diagnostic criteria for posttraumatic stress disorder (PTSD). This diagnosis is widely acknowledged to have had some of the most far-reaching and contested effects in civil and criminal matters. Andrew P. Levin, MD, Stuart B. Kleinman, MD, and John S. Adler, JD, explain how and why they predict that the new PTSD criteria will affect forensic psychiatric practice, including disability and

criminal responsibility assessments, civil litigation claims, assessments of victims of sexual trauma, and assessments involving veterans. They also examine the forensic significance of what is called the subthreshold presentations of PTSD.

Another highly debated area during the development process involved the classification of the paraphilic disorders. Diagnostic revisions that were deemed favorable for research purposes would have presented significant challenges for clinicians and forensic psychiatrists. Michael B. First, MD, evaluates the challenges faced by the Sexual and Gender Identity Disorders Work Group, the ultimate resolution, and how it may affect the practice of forensic psychiatry.

The modifications in the classification of neurodevelopmental and other disorders that have onset during childhood or adolescence are expected to influence the forensic practices of general and child psychiatrists. Some of these changes have also been highly controversial. These disorders are central in child forensic psychiatry, and at times central in adult disability evaluations, civil and criminal litigation, and mental health and educational policy. Cheryl D. Wills, MD, assesses the changes in these diagnoses, including the creation of autism spectrum disorder (formerly Asperger's disorder, autistic disorder, childhood disintegrative disorder, Rett's disorder, and pervasive developmental disorder-not otherwise specified) and intellectual disability (formerly mental retardation).

Discussions about the increasing prevalence of traumatic brain injury, dementia, and other neurocognitive disorders have been prevalent in the lay media, professional publications, and professional meetings. Joseph R. Simpson, MD, PhD, describes the dimensional classification schema of two new DSM-5 diagnoses: major and minor neurocognitive disorders. He describes how the changes may help forensic psychiatrists by facilitating their description of disorders of cognition on a continuum when writing forensic reports and during direct and cross-examination in court.

The aforementioned changes, and others, have resulted in a new DSM that will alter how we conceptualize and assess psychiatric disorders. It is a living document that will be refined as our understanding of the etiology, phenomenology, treatment, and prevention of mental disorders evolves. Time will reveal the ultimate impact of the 21st century's first major shift in diagnostic classification and evaluation. This Special Section represents an attempt in the early days of the new classification system to assist forensic psychiatrists in anticipating and identifying the strengths and limitations of DSM-5 and to formulate effective strategies to address the practical and theoretical challenges that its revision has created.

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