

# The Diagnostic and Statistical Manual of Mental Disorders in the Courts

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**The DSM is designed with the intention that it will be used in clinical and research contexts, not as a guide for the courts. Increasingly, from DSM to DSM-III-R, the introductory cautionary statement in the manual has warned against its use in the judicial context. The drafters of the DSM faced a choice and might have chosen to address in some greater detail those disordered behaviors that do have legal relevance in that they arise with some degree of regularity in the courts. The following essay examines this choice and its consequences.**

The history of the Diagnostic and Statistical Manual of Mental Disorders, although relatively brief, reveals a significant and interesting change of approach by its drafters regarding its use in the courts. The first edition of the DSM,<sup>1</sup> published in 1952, contains no express reference to its use in the courts. DSM-II,<sup>2</sup> published in 1968, however, contains in its foreword rosy words of optimism about its use in the judicial context:

In publishing the *Manual*, the American Psychiatric Association provides a service to the psychiatrists of the United States and presents a nomenclature that is usable in mental hospitals, psychiatric clinics, and in office practice. It has, in fact, a wider usage because of the growth of psychiatric work in general hospitals, both in psychiatric wards and consultation services to patients in other hospital departments, and in comprehensive community

mental health centers. *It will also be used in consultations to courts and industrial health services.*<sup>3</sup>

Twelve years later, in 1980, when DSM-III<sup>4</sup> appeared, the rosy optimism had waned. The foreword to DSM-III contained a cautionary statement designed to alert the user to the limits of its use in the judicial context:

The purpose of DSM-III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. *The use of this manual for non-clinical purposes, such as determinations of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context.*<sup>5</sup>

When DSM-III-R<sup>6</sup> appeared in 1987 the cautionary statement of its immediate predecessor was further strengthened:

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nose, communicate about, study, and treat various mental disorders. *It is to be understood that inclusion here, for clinical and research purposes, of a diagnostic category such as Pathological Gambling or Pedophilia does not imply that the condition meets legal or other nonmedical criteria for what constitutes mental disease, mental disorder, or mental disability. The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as responsibility, disability determination, and competency.*<sup>7</sup>

These changes in DSM-III and DSM-III-R were not the result of a systematic study of the DSM's use in the courts. Instead, they were based on an impression by the drafters that it had been misused in the courts.<sup>8</sup> The magnitude of this misuse, the specific nature of this misuse, or the manner in which this cautionary statement would address this misuse are not set forth.

The drafters of these manuals faced a choice. By their own acknowledgment, in the foreword to these manuals and elsewhere, the drafters recognized that many of the disorders included within the DSM are frequently of consequence in judicial determinations.<sup>9</sup> The drafters might have chosen to address in greater detail those behaviors that are legally relevant in that they arise in the courts with some regularity. This addressing of legally relevant behavior might be done in the DSM itself or in a separate supplementary manual. Or, in the alternative, the drafters might have chosen not to address legally relevant behavior either by not discussing the subject at all, as was done in DSM-I, or by providing an express disclaimer, as was done in DSM-III and DSM-III-R. The pur-

pose of this essay is to examine the choice actually made by the drafters and its consequences. Are society, the profession of psychiatry, and the legal system better served if this authoritative nosology of mental disorders specifically addresses legally relevant disordered behavior or if that task is left exclusively to witnesses appearing in individual cases?

There are four credible arguments against addressing legally relevant behavior in the DSM. First, psychiatrists have expertise in doing psychiatry, not in doing lawyering. Psychiatrists serve society, the legal system, and their profession best when they limit their professional conduct to their field of expertise.<sup>10</sup> Psychiatrists should confine themselves to studying, diagnosing, and treating mental disorders and not to discussing or describing the legal relevance of these disorders. More specifically, the DSM is a clinical guide. Its function is to assist psychiatrists in making diagnoses, not in determining the legal consequences of those diagnoses. That task is best left for others.

Second, if the DSM specifically addresses legally relevant behavior, there is a greater likelihood that individuals who lack the requisite knowledge and training in its use, specifically lawyers and judges, will use it inappropriately and without the complete diagnostic context. If legally relevant behavior were specifically addressed in the DSM, it would be easier for those without the requisite skills to seek to apply the diagnostic criteria in the DSM without realizing their limitations. And a discussion of legally relevant behavior in the DSM

might be perceived, symbolically, as permission for lawyers and judges to utilize the DSM on their own.

Third, a decision to incorporate an express discussion of legally relevant behavior in the DSM might result in making it frequently outdated. Legal rules change. Sometimes, it may seem, they do not change quickly enough. At other times legal rules change too quickly for even many lawyers to keep up to date. If the DSM were to address legally relevant behavior and the legal rules changed, the DSM would be outdated. Would such a DSM then require a yearly pocket part or supplement? Additionally, legal rules are not always uniform from state to state. For example, the test for insanity as a defense to criminal responsibility varies from state to state.<sup>11</sup> How could the DSM possibly deal adequately with these changes and variations?

The fourth argument against inclusion of legally relevant behavior in the DSM is an argument more likely to be advanced by lawyers than by psychiatrists. Addressing legally relevant behavior in the DSM would result in a usurpation by the American Psychiatric Association of judicial authority to make legal determinations, not on questions of pure science but questions of politics and values. American psychiatry is intellectually and theoretically diverse.<sup>12</sup> Of necessity, DSM-III, DSM-III-R, or any attempt to develop a single diagnostic paradigm out of this pluralistic tradition must involve compromises and choices between competing values.<sup>13</sup> Failing to recognize that science is not value neutral, the politics of science,<sup>14</sup>

there is a risk that a discussion of legally relevant behavior in the DSM would result, unwittingly, in legal incorporation of these value judgments of the American Psychiatric Association under the guise of "pure science."

These arguments are persuasive. They encounter significant problems, however, when they confront the reality of the practice of psychiatry in the courts and the use of the DSM in that context. In both civil and criminal cases the DSM has been used extensively. Psychiatrists and other mental health professionals testifying in a wide variety of cases from workers compensation,<sup>15</sup> insanity defenses,<sup>16</sup> sexual assault cases,<sup>17</sup> to domestic relations cases<sup>18</sup> refer extensively to the DSM. Lawyers and judges analyzing the weight to be given expert witnesses utilize the DSM and compare the consistency of their testimony with it.<sup>19</sup> The regulations for the evaluation of a disability under the Social Security Act specifically incorporate the DSM.<sup>20</sup> Indeed, the marketing of DSM-III-R specifically includes lawyer mailing lists. The use of the DSM in the courts is growing, and the magnitude and mode of its use appears unaffected by its cautionary statements. Thus the preceding arguments must be placed in the context of its actual use.

The first line of argument that inclusion of legally relevant behavior in the DSM requires psychiatrists to act beyond their sphere of professional expertise and changes the function of the DSM as a clinical guide is quite reasonable. The notion that psychiatrists should do psychiatry and not lawyering is valid. It is only germane to the dis-

cussion of legally relevant behavior in the DSM, however, if the DSM were to attempt to define or prescribe the legal consequences of disordered behavior. If, instead, the inclusion of legally relevant behavior in the DSM were confined to describing in detail what psychiatry knows about certain disorders that arise with some frequency in the legal system, leaving the legal conclusions to be drawn from this knowledge to the courts, the problem of psychiatrists acting beyond the limits of their expertise would be avoided.

An example of one potential legally relevant behavior, the current practice in the courts, and the relevant provision of the DSM is illustrative. Increasingly, "expert" witnesses have been offered to describe what they claim to be the symptoms of a particular type of posttraumatic stress disorder in sexually abused children, the "child sexual abuse accommodation syndrome."<sup>21</sup> This evidence is typically sought to be introduced by the prosecution in a criminal case for sexual assault of a child to prove that this child's behavior is consistent with the behavior of other sexually abused children thus making it more likely that this child was sexually abused. DSM-III-R, which recognizes posttraumatic stress disorder,<sup>22</sup> does not specifically address its symptoms in sexually abused children; the "expert" testimony in these cases does not appear to be based on symptoms described in the DSM. Reviews of the literature have concluded that the "child sexual abuse accommodation syndrome," as described by these witnesses, does not exist because of the widely differing ways in which children

have been reported to respond to this trauma.<sup>23</sup>

Claims of sexual abuse of children are a sad and altogether too frequent reality. If what is described as the "child sexual abuse accommodation syndrome" by these witnesses is a type of posttraumatic stress disorder and the research demonstrates that there are known and commonly understood symptoms of this syndrome, describing them in the DSM or a supplemental work is not beyond the bounds of psychiatry; it is psychiatrists doing psychiatry. And describing these symptoms directly furthers the goal of the DSM to assist "clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders."<sup>24</sup> If the "child sexual abuse accommodation syndrome" is not a type of posttraumatic stress disorder or the research does not demonstrate that its symptoms are currently known or commonly understood, there is an obligation on the profession of psychiatry to make this clear to the courts lest psychiatry suffer a loss of credibility and the judicial system suffer a loss of accuracy.

The second line of argument against the inclusion of legally relevant behavior in the DSM that specific inclusion would increase the likelihood of its use by individuals who lack the knowledge and skills to use it appropriately also expresses a legitimate concern. Just as it is dangerous for psychiatrists to do lawyering, it is equally dangerous for lawyers to do psychiatry. It is clear that some lawyers and judges currently use the DSM without appropriate professional guidance and would, in all likelihood, attempt to use it increasingly if legally

relevant behavior were specifically included.

The problem of the improper use of the DSM is not so easily disposed of however by choosing not to address legally relevant behavior in the DSM. A cautionary statement in the DSM's forward may avoid American Psychiatric Association complicity in its misuse, but it does not appear to have had the desired impact on the use of the DSM by lawyers and judges. Moreover, the increased potential for lawyers and judges to attempt to do psychiatry if the DSM were to address legally relevant behavior must be balanced against another problem that exists in part because of the DSM's failure to address legally relevant behavior. That problem is testimony by "expert" witnesses that goes beyond the limits of professional knowledge based on competent research. This problem is more extensive both in number and in effect than the problem of lawyers' or judges' attempting psychiatry and might be alleviated if the DSM addressed legally relevant behavior.

The problem of expert witnesses' reaching beyond their sphere of expertise exists for a variety of different reasons. Many difficult societal problems, such as epidemic crime rates and child abuse, fall in the lap of the judicial system which desperately seeks solutions. The judicial system is too often willing to disregard H. L. Mencken's admonition that for every complex problem in society there is a solution that is simple, appealing, and invariably wrong. The ethics of the adversary system require lawyers to present the available evidence that most strongly supports their client's

position, which often results in lawyers' turning to witnesses who offer answers to problems that most others in that profession claim cannot be answered at the present time. And, in criminal cases, the limited discovery available in many jurisdictions results in defense lawyers' often being ill prepared to respond to claims of purported experts offered by the prosecution.<sup>25</sup>

Given that many of the causes of this problem have been created or exacerbated by the legal system itself, it is reasonable to ask the legal system first to put its own house in order by demanding greater judicial scrutiny of purported experts. Without denying the legitimacy of this response, it is also clear that legal reforms alone will not be sufficient both in terms of the magnitude of the problem and in terms of the necessity for interprofessional assistance in this effort. Were legally relevant behavior addressed in the DSM, it might be possible to upgrade and make more uniform the psychiatric input in judicial decisions. These provisions would set clear guidelines for other professionals who rely upon this information and permit psychiatry to describe the limits of its knowledge and expertise. Witnesses proceeding beyond these bounds would be unable to rely on the collective knowledge of their profession. The knowledge of these limits is essential if informed and intelligent judicial decision making is to occur.

The third line of argument that inclusion of legally relevant behavior would make the DSM frequently outdated and that variations in rules from state to state would make the inclusion unworkable

assumes that a discussion of legally relevant behavior in the DSM would require that specific legal rules be included and applied. If, however, the DSM did not discuss and apply specific legal rules but instead addressed what psychiatrists know about this disordered behavior that might be relevant under a multitude of legal rules, this problem would be avoided.

Consider another example of post-traumatic stress disorder, this time in the context of an increasingly utilized version of the insanity defense relying upon what has been called Vietnam Veteran's stress syndrome.<sup>26</sup> The test for insanity in the United States varies principally from the M'Naughten<sup>27</sup> test, which exculpates for cognitive defects only, to the American Law Institute Test,<sup>28</sup> which adds a volitional component to the M'Naghten test. The decision to address the existence and symptoms of the Vietnam Veteran's Stress Syndrome in the DSM might include a summary of what is known about this syndrome from the available research and what light this research sheds on both the cognitive and volitional capacities of individuals who suffer from this disorder. There is no need to address in the DSM which insanity defense test should be used when describing in broad terms what is known about this behavior. That decision can and should be left to others.

The fourth line of argument against inclusion of legally relevant behavior in the DSM, the lawyer's argument, is that it would permit psychiatric usurpation of nonscientific issues in the judicial decisionmaking process. Of course, even without the inclusion of legally relevant

behavior in the DSM this risk exists. Much expert testimony cloaked with the veil of science contains unrevealed value judgments. If, however, legally relevant behavior were addressed specifically in the DSM it would carry a greater air of objectivity, the American Psychiatric Association's "Good Housekeeping Seal of Approval."

The issue posed by this risk might well be framed for lawyers and the courts in the following manner: With whom should the legal system be more concerned—the American Psychiatric Association as a deliberative body representing American psychiatry or those "expert" witnesses who strike out on their own beyond commonly accepted professional limits? Unfortunately, and almost by definition, one of the parameters of the problem is that the "renegade" experts are very persuasive. They offer judges and juries absolute answers to difficult questions when others in the profession are unable to answer these questions with certainty. Is not the lesser of these risks the potential usurpation by the American Psychiatric Association that will, inevitably, involve value judgments cloaked in the veil of science, compared to the individual decisions involving the renegade experts that may involve very persuasive witnesses providing nonscientific based testimony, inadequate lawyering, and inadequate time or funds to respond? And ultimately, of course, courts will not be found by the DSM and are thus at liberty to disregard their conclusions in appropriate cases.<sup>29</sup>

Addressing legally relevant behavior in the DSM is viable. A related effort by

the American Medical Association demonstrates this. The *Guides to the Evaluation of Permanent Impairment*<sup>30</sup> published by the American Medical Association addresses the evaluation of impairments of individuals seeking disability benefits from various statutory programs. One chapter of the *Guides* addresses mental and behavioral disorders. The *Guides* is currently in its second edition and has been adopted for use in several states in evaluating eligibility for disability benefits under various programs.<sup>31</sup>

The goal of addressing legally relevant behavior in an authoritative work on mental disorder was shared by Isaac Ray in his classic work, *A Treatise on the Medical Jurisprudence of Insanity*.<sup>32</sup> As Ray recognized, the decisions made in the legal system are too important and the knowledge of psychiatry often too relevant to these decisions to leave the proper integration of the two to happenstance. The judicial system should be the beneficiary of the best scientific knowledge psychiatry has to offer, not its best salesman. One significant way for the profession of psychiatry to assist in this process is to describe in the DSM in detail its knowledge of disordered behavior that is frequently relevant in legal determinations.

### References

1. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 1 ed. Washington, DC, American Psychiatric Association, 1952
2. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 2 ed. Washington, DC, American Psychiatric Association, 1968

3. *Id* at viii (emphasis added)
4. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 3 ed. Washington, DC, American Psychiatric Association, 1980
5. *Id* at 12 (emphasis added)
6. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 3 ed. rev. Washington, DC, American Psychiatric Association, 1987
7. *Id* at xxix (emphasis added)
8. Telephone conversation with Dr. Robert Spitzer, April 14, 1988. It is curious that in an empirically based diagnostic manual no empirical assessment of the use of the DSM in the courts was attempted. Such an assessment, at least in terms of reported judicial opinions, is easily done on computerized data bases such as LEXIS and Westlaw.  
Moreover, the underlying conclusion that the DSM has been misused may be subject to some doubt. The Foreword to DSM-III-R refers to Pathological Gambling as an area of apparent judicial misuse. The reported cases, however, reveal substantial wariness on the part of courts to conclude that a diagnosis of Pathological Gambling is a "get out of jail free card." See cases cited *infra* n. 26.
9. See e.g. Hyler, Williams, & Spitzer: Where, in DSM-III, is "compensation neurosis"? *American Journal of Forensic Psychiatry* 9:4 1988
10. See e.g. American Psychiatric Association Statement on the Insanity Defense (1982) ("It is clear that psychiatrists are experts in medicine, not the law. As such, it is clear that the psychiatrist's first obligation in the courtroom is to 'do psychiatry'. . . ."); Goldstein J, Freud A, Solnit A. In the Best Interests of the Child (1986).
11. See Shuman D. *Psychiatric and Psychological Evidence* § 12.02 (1986).
12. Klerman, *A Debate on DSM-III: The Advantages of DSM-III*, 141 *Am. J. Psychiatry* 141:539-42 1984
13. The words of Dr. Robert Spitzer, a principle architect of DSM-III and DSM-III-R, makes clear this process of compromise:

DSM-III is very much a human document. You have heard disparaging references to "committee work." If you accept the proposition that classifications are man-made—there is no mountain that we can go up to find (as certain religious documents are alleged to have developed)—then it follows that committees are all we have. Classification systems are made by people, and the only questions are, How do these people function together? Who are they? How wise are they? What kind of evidence do they examine?

- Spitzer R, A debate on DSM-III: first rebuttal. *Am J Psychiatry* 141:546 1984; See also Spitzer, The diagnostic Status of homosexuality in DSM-III: a reformulation of the issues. 138 *Am J Psychiatry* 138:210-4 1981 ("The concept of 'disorder' always involves a value judgment.")
14. See e.g. Malt, *Philosophy of Science and DSM-III: Philosophical, Idea-History and Sociological Perspectives in Diagnoses*, 10 *Acta Psychiatrica Scand* 328 1986; Schact, *DSM-III and the Politics of Truth*, 40 *Am. Psychol.* 513 (1985); Kaplan, *A Woman's View of DSM-III*, 38 *Am. Psychol.* 786 (1983).
  15. *Kramer v. United States*, 579 F. Supp. 314 (D. Md. 1984); *Saunderlin v E.I. Dupont Co.*, 102 N.J. 402, 508 A.2d 1095 (1986); *In re McGarrah*, 296 Ore. 145, 675 P.2d 159 (1983).
  16. The use of the DSM has occurred in a broad variety of cases including pathological or compulsive gambling—(*United States vs. Gillis*, 773 F.2d 549 (4th Cir. 1986); *United States v. Davis*, 772 F.2d 1339 (7th Cir. 1985); *United States v. Gould*, 741 F.2d 45 (4th Cir. 1984); *United States v. Torniero*, 735 F.2d 725 2nd Cir. 1984); *United States v. Lewellyn*, 723 F.2d 615 (8th Cir 1983); *United States v. Shorter*, 618 F. Supp. 255 (D.D.C. 1985); battered women's syndrome—*State v. Hodges*, 241 Kan. 183, 734 P.2d 1161 (1987); and Vietnam veteran's stress syndrome—*State v. Felde*, 422 So.2d 370 (La. 1982); *Miller v. State*, 338 N.W. 2d 673 (S.D. 1983).
  17. In the following cases Rape Trauma Syndrome was sought to be introduced to prove that a victim of sexual assault did not consent to sexual relations. *State v. Allewalt*, 308 Md. 89, 517 A.2d 741 (1986); *State v. Goodwin*, 320 N.C. 147, 357 S.E.2d 639 (1987); *Scadden v. State*, 732 P.2d 1036 (Wyo. 1987).
  18. *In re C.B.*, 740 P.2d 11 (Colo. 1987); *In re Dayley*, 112 Idaho 522, 733 P.2d 743 (1987).
  19. See e.g., *State v. Huntley*, 302 Or. 418, 730 P.2d 1234 (1986).
  20. 20 C.F.R. 404, sub P, App. 61.
  21. See e.g. *United States v. St. Pierre*, 812 F.2d 417 (8th Cir. 1987); *State vs. Moran*, 151 Ariz. 378, 728 P.2d 248 (1986); *People v. Gray*, 187 Cal. App. 3d 213, 231 Cal. Rptr. 658 (1987); *Kruse v. State*, 483 So. 2d 1383 (Fla. Dist. Ct. App. 1986); *Allison v. State*, 346 S.E.2d 380 (Ga. Ct. App. 1986).
  22. DSM-III-R at 247-50
  23. McCord, *Expert Testimony About Child Complaints in Sexual Abuse Prosecutions: A Foray into the Admissibility of Novel Psychological Evidence*, 77 *J. Crim. L. & Criminology* 1 (1986); Note, *The Unreliability of Expert Testimony on the Typical Characteristics of Sexual Abuse Victims*, 74 *Geo. L.J.* 429 (1985).
  24. DSM-III-R at xxix.
  25. See e.g. *United States v. St. Pierre*, 812 F.2d 417 (8th Cir. 1987). The limited discovery in criminal cases is a function of measures designed to protect the defendant from being required to help the government convict him—the Fifth Amendment privilege against selfincrimination—and measures designed to protect prosecution witnesses from intimidation by defendants. See generally Eads, *Adjudication by Ambush: Federal Prosecutor's Use of Nonscientific Experts in a System of Limited Criminal Discovery* (1988) (unpublished manuscript).
  26. See e.g. *People v. Lisnow*, 88 Cal. App. 3d 21, 151 Cal. Rptr. 621 (1978).
  27. 2 *Eng. Rep.* 718 (1843).
  28. Model Penal Code § 401(1) (proposed official draft 1962).
  29. *Barefoot v. Estelle*, 463 U.S. 880 (1983). Although *Barefoot* is a distressing example of the fact that the legal system has not always heeded the advice of the American Psychiatric Association in appropriate cases, that advice has had a greater impact than might be realized on the surface. It has increased the awareness of judges and lawyers to the limits of professional competence and sharpened the focus on these concerns. Moreover, any conclusions about the impact of psychiatry on the judicial process drawn from *Barefoot* must take into account that it is a decision mired in the politics of the death penalty on a course set in earlier cases on issues unrelated to psychiatric input in death penalty cases.
  30. American Medical Association, *Guides to the Evaluation of permanent Impairments* (2 ed. 1984); American Medical Association, *Guides to the Evaluation of Permanent Impairments* (1971).
  31. Fla. Stat. Ann. § 440.15(3) (a) (West Supp. 1987); La. Rev. Stat. Ann. § 23:1221(4) (q) (West Supp. 1988); Nev. Rev. Stat. § 616.605(2) (1985); Okla. Stat. Ann. tit. 85, §3 (11) (West Supp. 1987); Wyo. Stat. § 27-14-405(a) (1987).
  32. Ray I, *A Treatise on the Medical Jurisprudence of Insanity* (1838). Ray stated that his goal was "to furnish a single work in which the various forms and degrees of mental derangement are treated in reference to their effect on the rights and duties of man." *Id* at 6.