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Could the American Psychiatric Association Cause You Headaches? The Dangerous Interaction between the *DSM-5* and Employment Law

Douglas A. Hass*

INTRODUCTION

Since its first publication in 1952, the American Psychiatric Association's ("APA" or the "Association") *Diagnostic and Statistical Manual of Mental Disorders* ("*DSM*" or the "*Manual*")¹ has long served as the primary reference for mental health disorders not only for medical practitioners, but also for state and federal courts and government agencies like the Social Security Administration and Veterans Administration. In 1994, the APA published the fourth edition of the *DSM*, or *DSM-IV*, with only minor "text revisions" in 2000. In May 2013, for the first time in nearly twenty years, the APA plans to publish an entirely new edition.² As proposed, the *DSM-5* (the Association plans to abandon using Roman numerals)³ would significantly expand a number of existing psychological disorders and add several new ones. The *DSM-IV*, like previous editions of the *DSM*, has long served as a primary authority for the legal community. The new *Manual* is still somewhat of an unknown, both in terms of content

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1. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (4th ed. text rev. 2000) [hereinafter *DSM-IV*]. The *DSM-IV* is the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. Although the current version is technically the 2000 text revision (the "*DSM-IV-TR*") rather than the 1994 version of *DSM-IV*, legal and agency practitioners rarely differentiate between the two. Accordingly, unless otherwise stated, this Article will rely on the 2000 text revision and refer to it only as the *DSM-IV*.

2. Press Release, Am. Psychiatric Ass'n, *DSM-5 Publication Date Moved to May 2013* (Dec. 10, 2009), <http://www.dsm5.org/Newsroom/Documents/09-65%20DSM%20Timeline.pdf>.

3. Press Release, Am. Psychiatric Ass'n, *APA Modifies *DSM* Naming Convention to Reflect Publication Changes* (Mar. 9, 2010), <http://www.dsm5.org/Documents/DSM-Name-Change.pdf>.

and potential impact. The APA originally published proposed diagnostic criteria and assessment instruments on the *DSM-5* website.⁴ The APA's Board of Trustees subsequently adopted the final *DSM-5* on December 2, 2012, but offered little detail in its announcement and papered over the closed nature of the *Manual*'s development.⁵ The Board's approval did little to quell controversies over the *DSM-5*'s impending publication.⁶

Significant proposed revisions to a wide range of mental impairments in the final public draft of the *DSM-5* indicate that the legal community's relationship with the *DSM* may be forced to change, given the implications that changes in the *DSM-5* may have for claims under laws like the Americans with Disabilities Act (ADA) (regarding claims of "disability" and requests for reasonable accommodations), Family Medical Leave Act (FMLA) (regarding definitions of a "serious illness"), Age Discrimination in Employment Act (ADEA), and even state statutes and workers compensation laws (regarding whether an illness is work related).

The great weight given to the *DSM-IV* is often overlooked outside of the medical field. However, as this Article explains, the *DSM-IV*'s definitions of mental disorders and their severity have frequently served as references for courts and administrative agencies looking to interpret statutes and regulations and to apply the law to factual scenarios. Even if a *DSM-IV*-based diagnosis has not always presumptively meant an employee was covered under various employment laws, the legal community must not overlook the potential impact of the new *DSM-5* on employment laws. The *DSM-5* will likely impact whether

4. *DSM-5: The Future of Psychiatric Diagnosis*, AM. PSYCHIATRIC ASS'N, <http://www.dsm5.org/> (last visited Oct. 30, 2012).

5. See Press Release, Am. Psychiatric Ass'n, American Psychiatric Association Board of Trustees Approves *DSM-5* (Dec. 1, 2012) [hereinafter APA Approves *DSM-5*]. Notwithstanding the interaction described in note 4 above, and the criticisms about the closed and secret process by the *DSM-5*'s critics discussed in this Article, the APA's press release nonetheless claimed that the *DSM-5* development process was "open and inclusive." Similarly, although the press release claimed that "the *DSM-5* Task Force and Work Groups reviewed and considered each response" from the public, and "made revisions where warranted," it failed to describe any such considerations or revisions. For example, the December 2012 release confirmed the removal of the "bereavement exclusion" from the definition Major Depressive, discussed in Part IV *infra*. This important definitional revision is unchanged from the last public draft criteria.

6. See, e.g., Allen Frances, *One Last Chance for the APA to Make the *DSM-5* Safer*, HUFFINGTON POST (Dec. 17, 2012), http://www.huffingtonpost.com/allen-frances/one-last-chance-for-the-apa-to-make-the-dsm-5-safer_b_2294868.html; Peter Whoriskey, *Antidepressants to Treat Grief? Psychiatry Panelists with Ties to Drug Industry Say Yes*, WASH. POST (Dec. 26, 2012), http://articles.washingtonpost.com/2012-12-26/business/36015527_1_drug-companies-antidepressants-wellbutrin (discussing criticisms of the APA's removal of the "bereavement exclusion").

employees can bring claims under the ADA, FMLA, ADEA, and various state statutes.

This Article discusses the major role that the *DSM* standards play for legal practitioners and the danger that overly expansive definitions of mental disorders could pose to employers and employees. Part I discusses the history and background of the *DSM* and its development into a de facto legal treatise. Next, Part II highlights the strengths and weaknesses of the *DSM-IV* as a legal text. Part III then explains the dangerous interaction between the ADA Amendments Act and the proposed *DSM-5*. In Part IV, the Article highlights the challenges and difficulties that certain changes—from a proposed “Mild Neurocognitive Disorder” to the inclusion of deviant behavior in the definition of a mental disorder—could cause employers, employees, courts, and even federal agencies in applying employment and disability laws, particularly the ADA. Finally, to reduce the possibly unintended consequences of overly expansive definitions, Part V summarizes specific approaches that courts, employers, employees, and legal practitioners should rely on to reduce any potential confusion and burdens caused by the release of the *DSM-5*.

I. THE DEVELOPMENT OF THE *DSM* INTO A DE FACTO LEGAL TREATISE

Mental health practitioners, insurance companies, and lawyers practicing employment law, disability law, and other related areas, use the *DSM* and have elevated it to the level of a de facto legal treatise.⁷ The *Manual* contains uniform psychiatric standards developed by the APA that define and classify mental and emotional disorders. The *DSM* also establishes detailed criteria that medical professionals use to uniformly identify mental conditions, evaluate symptoms, establish diagnoses, and decide on appropriate treatment.⁸

A. *Early Development*

Prior to the 1920s, the psychiatric field often inconsistently applied diagnostic categories for mental disorders.⁹ The inconsistencies from practitioner to practitioner led to a movement to create a standardized framework for diagnosing mental and emotional disorders and to use uniform terminology and classifications.¹⁰ In 1928, the New York

7. See *infra* notes 56–63 and accompanying text (discussing the extent to which professionals use the *DSM* within the legal community).

8. *DSM-IV*, *supra* note 1.

9. ANTHONY L. LABRUZZA & JOSÉ M. MÉNDEZ-VILLARRUBIA, USING DSM-IV: A CLINICIAN'S GUIDE TO PSYCHIATRIC DIAGNOSIS 13 (2d ed. 1997).

10. *Id.*

Academy of Medicine held a National Conference on the Nomenclature of Diseases in order to address the concerns of this movement.¹¹ In 1932, the Conference published the first edition of *A Standard Classified Nomenclature of Disease (SCND)*.¹² The *SCND*'s first edition focused on standardizing and labeling severe neurological and psychiatric disorders that practitioners had identified in mental patients.¹³

With the *SCND*, mental health practitioners could, for the first time, apply a uniform approach to the diagnosis and treatment of psychiatric disorders. However, the *SCND*'s limited diagnostic categories proved insufficient to diagnose the range of mental disorders exhibited by soldiers returning from World War II.¹⁴ In fact, more than 90% of the symptoms that military psychiatrists observed in veterans fell outside the *SCND*'s diagnostic categories.¹⁵ To account for this broader range of disorders in World War II veterans, the United States Army and Navy sought to expand on the *SCND* standards.¹⁶ This effort culminated in the Veterans Administration's creation of a separate, comprehensive psychiatric standard in 1946.¹⁷ Relying heavily on the Veterans Administration's standard, the sixth edition of the *International Classification of Diseases (ICD-6)*, published in 1948, for the first time included a section on mental disorders.¹⁸

Once again, the psychiatric community faced divergent standards and terminology, including the *SCND*, the Veterans Administration's standard, and the *ICD-6*. In response, the APA established the Committee on Nomenclature and Statistics to review the differing standards.¹⁹ In 1952, the Committee published its findings and conclusions as the first edition of the *Diagnostic and Statistical Manual*

11. *Id.*

12. *Id.*

13. *Id.*

14. *Id.* at 14. For instance, the *ICD-6*, discussed *infra* note 18, and the *DSM-I*, discussed *infra* note 20, created the first formulations of what is now known as post-traumatic stress disorder, or PTSD. The *ICD-6* termed the disorder "acute situational maladjustment," while the *DSM-I* referred to it as "transient situational personality disturbance."

15. LABRUZZA & MÉNDEZ-VILLARRUBIA, *supra* note 9, at 14.

16. *Id.*

17. *Id.*

18. *Id.* Originally known as the *International Classification of Causes of Death*, the *ICD*'s sixth edition effectively supplanted the *SCND*. *History of the Development of the ICD*, WORLD HEALTH ORG., <http://www.who.int/classifications/icd/en/HistoryOfICD.pdf> (last visited Sept. 27, 2012). The *ICD* was subsequently harmonized with the diagnostic codes and terminology used by the *DSM*. See WILLIAM H. REID & MICHAEL G. WISE, *DSM-IV TRAINING GUIDE 6* (1995) (discussing harmonization between the *ICD* and the *DSM*).

19. LABRUZZA & MÉNDEZ-VILLARRUBIA, *supra* note 9, at 14.

of *Mental Disorders*, or *DSM-I*.²⁰

B. Expanding the DSM: From DSM-I to DSM-IV

The Association's release of *DSM-I*, however, did not quell the controversy over divergent standards. Instead, *DSM-I* introduced more controversy and confusion, in large part due to differences in its classification system and the one used by the *ICD-6* (and, in 1955, the *ICD-7*).²¹ To address these concerns, in 1968 the APA and the World Health Organization's Eighth Revision Conference published the *DSM-II* and *ICD-8* as a collaborative effort aimed at harmonizing the competing classification systems.²² The *DSM-II*, using a hierarchy of classifications that operated from the top down, divided mental disorders into psychoses and nonpsychoses. It then subdivided psychotic disorders into organic versus functional categories, while separating nonpsychotic disorders into neuroses, personality disorders, and mental retardation. Each classification acted as a subordinate of the one above it, mirroring the biological process of evolution (i.e., a top-down classification system).²³

A taxonomy built to classify organisms in a single species was a poor fit for multifaceted psychiatric diagnoses. The hierarchical classifications proved both ambiguous—the differences between neurotic and psychotic disorders were poorly defined—and overly restrictive—the classifications limited clinicians' ability to diagnose patients with multiple disorders. For example, under the *DSM-II*, a psychiatrist could not diagnose a patient with both an organic disorder and schizophrenia because they occupied different branches of the *DSM-II*'s top-down hierarchy.²⁴

In 1980, with the impending release of *ICD-9*, the APA again revised the *DSM*.²⁵ The *DSM-III* eliminated the hierarchical classifications found in *DSM-II* and created new diagnostic categories centered on grouping disorders based on similar kinds of symptoms—including Mood, Anxiety, Somatoform, and Dissociative Disorders—in a

20. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (1st ed. 1952).

21. LABRUZZA & MÉNDEZ-VILLARRUBIA, *supra* note 9, at 14.

22. REID & WISE, *supra* note 18, at 4. See AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (2d ed. 1968) (stating that the goal of the *ICD-8* is to unify varying standards).

23. AM. PSYCHIATRIC ASS'N, DSM-IV OPTIONS BOOK: WORK IN PROGRESS 1 (1991).

24. *Id.*

25. REID & WISE, *supra* note 18, at 4; AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. 1980) [hereinafter *DSM-III*].

multiaxial system.²⁶ Additionally, the *DSM-III* allowed for the first time the possibility of multiple diagnoses, further distancing itself from the hierarchies defined in the *DSM-I* and *DSM-II*.²⁷

To coincide with the release of the *ICD-10*, the APA again revised the *DSM* in 1994.²⁸ The *DSM-IV*, the most comprehensive diagnostic manual to date, made numerous changes and additions to the *DSM-III*.²⁹ For example, the *DSM-IV* provided for psychosocial and environmental problems that influence the diagnosis, treatment, and prognosis of mental disorders.³⁰ These factors included major (often negative) life events, familial or other interpersonal stressors, and a lack of social support or personal resources.³¹ A major change in the *DSM-IV* from previous versions of the *Manual* was the addition of a clinical significance criterion to almost half of all the diagnostic categories.³²

II. STRENGTHS AND WEAKNESSES OF THE *DSM* AS A LEGAL TEXT

A. *DSM-IV: A Critical Diagnostic Tool, but Not a Medical "Bible"*

Even before the APA began developing the *DSM-5*, the *DSM-IV* faced its own wave of criticism from scholars, particularly on the development of the diagnostic categories.³³ Critics also complained of political pressure on the APA's process for creating the *DSM-IV*.³⁴ However, and notwithstanding the deference that the legal community

26. *DSM-III*, *supra* note 25.

27. *Id.*

28. REID & WISE, *supra* note 18, at 5.

29. The Association had made minor revisions to the *DSM-III* in 1987. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (3d ed. rev. 1987).

30. *DSM-IV*, *supra* note 1, at 28 (provided in Axis IV).

31. See Ruth Ross et al., *Gender Issues in DSM-IV*, in 14 REVIEW OF PSYCHIATRY 205, 209 (John M. Oldham & Michelle B. Riba eds., 1995) (discussing the factors that influence the general treatment of mental disorders).

32. See generally John M. Oldham, *Personality Disorders*, in 3 FOCUS 372 (2005).

33. See, e.g., James J. Strain, *Psychiatric Diagnostic Dilemmas in the Medical Setting*, 39 AUSTL. & N.Z. J. PSYCHIATRY 764, 766–67 (2005) (criticizing attempts in the *DSM-IV-TR* and previous editions to develop diagnostic systems to categorize and explain mental illness); Dr. Randall D. Marshall et al., *Review and Critique of the New DSM-IV Diagnosis of Acute Stress Disorder*, 156 AM. J. OF PSYCHIATRY 1677 (1999). See also HERB KUTCHINS & STUART A. KIRK, MAKING US CRAZY: DSM: THE PSYCHIATRIC BIBLE AND THE CREATION OF MENTAL DISORDERS (2003) (broadly criticizing the application of mental illness labels to normal life processes).

34. See, e.g., John Z. Sadler & Bill Fulford, *Should Patients and Their Families Contribute to the DSM-V Process?*, 55 PSYCHIATRIC SERVS. 133, 134 (2004) (stating that the creation of *DSM-IV-TR* was hampered by lobbying and partisan politics); accord John Z. Sadler et al., *On Values in Recent American Psychiatric Classification*, 19 J. MED. & PHIL. 261, 261–62 (1994) (explaining that *DSM-IV-TR* authors paid little attention to value considerations).

often gives the *DSM*,³⁵ the *DSM-IV* is simply a consensus-built medical text with the attendant limits.³⁶ It is not a psychiatric “bible.”³⁷ The APA appoints subject matter experts on a particular diagnosis to a committee and tasks them with developing a consensus on how the literature and research define the criteria for a certain diagnosis.³⁸ The committees develop and revise diagnoses in each subsequent edition of the *Manual* based on research and clinical experience.³⁹

Accordingly, the *DSM* is useful when classifying patients for insurance, research, or treatment purposes. The *Manual* serves physicians, patients, and insurers alike when evaluating whether a patient meets certain diagnostic criteria required for a referral, health benefits, or insurance coverage. Researchers can use the *DSM* to treat patients dispersed both geographically and across multiple studies to ensure that they evaluate similar patients using specific, predefined diagnostic criteria—an important and obvious issue for treatment research. The *DSM-IV*’s multiaxial assessment also increases the ease with which practitioners can evaluate patients with multiple conditions and stressors beyond a primary diagnosis using the Global Assessment of Functioning (“GAF”) score.⁴⁰

For legal practitioners, the *DSM-IV* helpfully defines a mental disorder as “a clinically significant behavioral or psychological syndrome” that is attendant with “present distress” or “disability.”⁴¹ Importantly, this criterion requires symptoms to cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning.”⁴² The *DSM-IV* also defines what is *not* a mental disorder: “an expectable and culturally sanctioned response to a particular event.”⁴³ Furthermore, the *DSM-IV* excludes deviant behavior or conflicts with society from the mental disorder

35. See *infra* notes 56–63 and accompanying text (discussing the legal community’s views and usage of the *DSM*).

36. *DSM-IV*, *supra* note 1, at xxxiii.

37. Andrew E. Taslitz, *Mental Health and Criminal Justice: An Overview*, 22 CRIM. JUST. 4, 5 (2007).

38. *DSM-IV*, *supra* note 1, at xxxiii.

39. *Id.* at xxxi–xxxiii.

40. See, e.g., *Jelinek v. Astrue*, 662 F.3d 805, 807 & n.1 (7th Cir. 2011) (defining GAF score as a “psychiatric measure of a patient’s overall level of functioning”).

41. *DSM-IV*, *supra* note 1, at xxxi. But see *DSM-IV*, *supra* note 1, at xxx (“[I]t must be admitted that no definition adequately specifies precise boundaries for the concept of ‘mental disorder.’”).

42. See Robert L. Spitzer & Jerome C. Wakefield, *DSM-IV Diagnostic Criterion for Clinical Significance: Does It Help Solve the False Positives Problem?*, 156 AM. J. OF PSYCHIATRY 1856 (1999).

43. See *DSM-IV*, *supra* note 1, at xxxi.

classification, unless the deviance and conflicts are symptoms of another mental disorder identified in the *Manual*. As discussed in Part IV, the *DSM-5* proposes to relax these important foundational definitions in many areas.

B. DSM-IV: An Informational, Not Authoritative, Legal Text

The *DSM-IV*, however, is not without its weaknesses. More specifically, the sheer number of mental disorders encompassed by the *DSM-IV* can create confusion in legal contexts.⁴⁴ A comparison of the *DSM-IV* with the *DSM-I* demonstrates one reason why: the *DSM-IV* lists 297 different mental disorders, or approximately 300% more than the *DSM-I* published just forty-two years earlier.⁴⁵

Unfortunately, the rapid expansion of listed mental illnesses was not the result of improvements in medical diagnoses.⁴⁶ For example, the *DSM-IV* added seventeen new sexual disorders, “despite little to no empirical evidence of any underlying disease process that could account for their existence.”⁴⁷ Other new diagnoses in the *DSM-IV* included personality disorders, which are pervasive and rigid patterns of maladaptive behavior.⁴⁸ Rather than objective markers, the *DSM-IV* identifies personality disorders by “an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture.”⁴⁹ Accordingly, psychiatrists must rely on subjective cultural standards to diagnose these types of disorders.

Among several cautionary statements that implicitly recognize the

44. In no way should readers conflate confusion in *legal* environments with confusion in *medical* or *societal* ones. Mental illnesses are real and affect millions of Americans. Sadly, Americans with mental illnesses still face numerous burdens and stigmas in society. See Jane Byeff Korn, *Crazy (Mental Illness under the ADA)*, 36 U. MICH. J.L. REFORM 585, 586–87 (2003) (describing stereotypes and stigmas associated with the mentally ill). People tend to fear the mentally ill, discriminate against them, and view them as more likely to perpetrate violent acts than others with only physical illnesses. *Id.* Even after the passage of the ADA, group insurance plans can still provide more benefits for physical disabilities than mental disabilities without violating that law’s anti-discrimination provisions. *Weyer v. Twentieth Century Fox Film Corp.*, 198 F.3d 1104, 1115–18 (9th Cir. 2000). While I am of the opinion that wholesale reliance on or adoption of the *DSM* by legal practitioners may be dangerous, that opinion should always be viewed in a greater societal context. Ignorance of the prevalence and devastating effects of mental illness is a serious issue that no legal analysis of the *DSM* can or should diminish.

45. Compare *DSM-IV*, *supra* note 1, at 13–26 (listing all recognized disorders), with *DSM-I*, *supra* note 20.

46. See Steven K. Erickson, *The Myth of Mental Disorder: Transsubstantive Behavior and Taxometric Psychiatry*, 41 AKRON L. REV. 67, 105–06 (2008) (tying illnesses to political pressures and theoretical factors unsupported by clinical research).

47. *Id.* at 114.

48. *DSM-IV*, *supra* note 1, at 685.

49. *Id.* at 686.

Manual's limitations, the *DSM-IV* warns that the "assignment of a particular diagnosis does not imply a specific level of impairment or disability."⁵⁰ Therefore, an individual may be depressed, and even meet the *DSM-IV*'s diagnostic criteria for Major Depressive Disorder, but those facts alone may or may not result in a level of functional impairment warranting a medical determination of disability. Accordingly, a diagnosis of a mental illness under the *DSM-IV* cannot directly translate to a legal determination of incompetence, disability, or lack of criminal responsibility. A murderer may have Bipolar Disorder, Major Depressive Disorder, and various psychoses, but still be found competent to stand trial.⁵¹ Of course, a *DSM-IV* diagnosis necessarily implies nothing about the treatment protocol for the mental illness—a diagnosis cannot inform a court whether medication or other treatment can help a person "control" their condition.

The lack of clarity in the *DSM-IV* about how to define a mental illness,⁵² particularly when combined with diagnostic subjectivity in certain disorders, presents significant difficulties for legal practitioners who look to the *DSM* either to adapt medical terminology to lay, legal definitions, or to reach legal conclusions.⁵³ Even Congress has rejected a statutory definition that would explicitly require group health plans to adopt all *DSM* diagnoses.⁵⁴

50. *Id.* at xxxiii.

51. *E.g.*, United States v. Loughner, 672 F.3d 731 (9th Cir. 2012). The Ninth Circuit affirmed a district court's finding that Jared Lee Loughner, who shot and killed federal judge John Roll and seriously wounded Congresswoman Gabrielle Giffords (among others) in January 2011, was competent to stand trial despite multiple mental disorders. *Id.* at 772. The district court had found a substantial probability that Loughner could be restored to competency through involuntary medication. *Id.* at 770.

52. *See DSM-IV*, *supra* note 1, at xxx ("[I]t must be admitted that no definition adequately specifies precise boundaries for the concept of 'mental disorder.'").

53. *See, e.g.*, Pierre Beumont & Terry Carney, *Can Psychiatric Terminology Be Translated into Legal Regulation? The Anorexia Nervosa Example*, 38 AUSTL. & N.Z. J. PSYCHIATRY 819, 820 (2004).

54. As part of Public Law No. 110-343, 122 Stat. 3765 (2008)—a law best known for creating the Troubled Asset Relief Program (TARP)—Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA, codified in relevant part at 29 U.S.C. § 1185a (2006), requires insurance coverage for treatment related to mental health or substance abuse to be "no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan" and eliminated disparities between co-pays and deductibles for mental versus physical illnesses. The original version of the bill, introduced in March 2007, explicitly required group health plans to "include benefits for any mental health condition or substance-related disorder included in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association." H.R. 1424, 110th Cong. (2007). This language was removed prior to the passage of the MHPAEA.

C. Use of the DSM in Legal Contexts

Despite these weaknesses and the *DSM*'s admonitions that the application of *DSM-IV* "categories, criteria, and textual descriptions . . . for forensic purposes," rather than medical ones, raises "significant risks that diagnostic information will be misused or misunderstood,"⁵⁵ the *DSM-IV* has found wide application far beyond doctors' offices and medical journals. Courts, legislators, and government agencies have relied on the *DSM-IV* as a persuasive text in a range of cases implicating mental illness, from employment discrimination,⁵⁶ to criminal law⁵⁷ and Social Security disability,⁵⁸ and even to health plan administration.⁵⁹ Courts have referred to the *DSM* as a "nationally recognized directory of mental illness,"⁶⁰ a "reliable text,"⁶¹ and "specialized literature" with a rigorous process for including mental illnesses.⁶² Courts have also held that government agencies can reasonably rely on the *DSM-IV* to determine eligibility for their health plans' disability benefits.⁶³

Battles over the *DSM* and its proper meaning have even reached Supreme Court decisions. For example, in *Atkins v. Virginia*,⁶⁴ the Court considered the constitutionality of imposing the death penalty on intellectually disabled/mentally retarded defendants. Writing for the

55. *DSM-IV*, *supra* note 1, at xxxii–xxxiii.

56. *See, e.g.*, *Scheerer v. Potter*, 443 F.3d 916, 920–21 & n.2 (7th Cir. 2006) (rejecting "disability" in Rehabilitation Act claim in part because of the *DSM-IV* definition of adjustment disorder); *Boldini v. Postmaster Gen.*, 928 F. Supp. 125, 130 (D.N.H. 1995) (stating, under section 501 of the Rehabilitation Act, that "in circumstances of mental impairment, a court may give weight to a diagnosis of mental impairment which is described in the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association"); *Guice-Mills v. Derwinski*, 772 F. Supp. 188, 197–98 (S.D.N.Y. 1991) ("A major depressive episode as described in the [*DSM-IV*] constitutes 'mental impairment' [under the Rehabilitation Act]."), *aff'd*, 967 F.2d 794 (2d Cir. 1992).

57. *See, e.g.*, *Clark v. Arizona*, 548 U.S. 735, 774 (2006) (citing *DSM-IV*'s diagnostic definition of Schizophrenia in a case regarding state insanity defense standards).

58. *See, e.g.*, *Jelinek v. Astrue*, 662 F.3d 805, 807 n.1 (7th Cir. 2011) (citing the *DSM-IV* definition of a GAF score—a "psychiatric measure of a patient's overall level of functioning"—in a disability case involving mental impairments).

59. *See Fuller v. J.P. Morgan Chase & Co.*, 423 F.3d 104, 105–06 (2d Cir. 2005) (citing a disability plan's reliance on *DSM-IV* definitions when making disability coverage determinations).

60. *Pandazides v. Va. Bd. of Educ.*, 804 F. Supp. 794, 803 (E.D. Va. 1992), *rev'd on other grounds*, 13 F.3d 823 (4th Cir. 1994).

61. *United States v. Danser*, 110 F. Supp. 2d 807, 829 (S.D. Ind. 1999).

62. *Discepolo v. Gorgone*, 399 F. Supp. 2d 123, 127 (D. Conn. 2005).

63. *Dellarciprete v. Gutierrez*, 479 F. Supp. 2d 600, 605 (N.D.W.V. 2007) ("[T]he BOP's reliance on the *DSM-IV* to help determine the terms of eligibility is likewise reasonable.")

64. 536 U.S. 304 (2002).

majority, Justice Stevens referred to both the *DSM-IV*⁶⁵ and the joint amicus curiae brief filed by the American Psychological Association and the APA.⁶⁶ His opinion stated that “clinical definitions of mental retardation require not only subaverage intellectual functioning, but also significant limitations in adaptive skills . . . that became manifest before age 18.”⁶⁷ In dissent, Justice Scalia focused on this definition and remarked that “the symptoms of this condition can readily be feigned.”⁶⁸

Thus, even at the highest levels, legal practitioners and legislators often rely heavily on the *DSM-IV* when making legal determinations—in *Atkins*, to determine whether intellectual disability/mental retardation can be diagnosed in a defendant; for Congress, to determine the scope of coverage under group health plans. This overreliance, however, is dangerous. The *DSM* increasingly lists sets of “hypotheses, somewhat proved and somewhat unproved, that were reliably defined so as to be further studied and later further refined, proved, or disproved,” rather than listing disorders.⁶⁹ Nevertheless, the seemingly blind obeisance in legal circles for the *DSM* results in practitioners, courts, and judges—not to mention employers and employees—treating a *DSM* diagnosis as a proven fact with legal consequences, rather than the hypothesis that it often represents.⁷⁰

The *DSM-IV* actually cautions the legal community from attaching too much importance to the *Manual* when making conclusions of law and explains why heavy reliance is dangerous:

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-IV* mental disorder is not sufficient to establish the existence for legal purposes of a “mental disorder,” “mental disability,” “mental disease,” or “mental defect.” In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility,

65. See *id.* at 308 n.3 (quoting the APA’s definition of Mental Retardation).

66. See *id.* at 316 n.21 (citing the APA’s amicus curiae brief opposing the imposition of the death penalty on offenders diagnosed with mental retardation).

67. *Id.* at 318.

68. *Id.* at 353 (Scalia, J., dissenting).

69. S. NASSIR GHAEMI, *THE CONCEPTS OF PSYCHIATRY: A PLURALISTIC APPROACH TO THE MIND AND MENTAL ILLNESS* 172 (2003).

70. See, e.g., *id.* at 53 (discussing the difficulty in reconciling psychiatry and empiricism); Philip Thomas et al., *Explanatory Models for Mental Illness: Limitations and Dangers in a Global Context*, 2 PAK. J. NEUROL. SCI. 176, 177 (2007) (discussing the lack of evidence that links psychiatric disorders to biology); John Sorboro, *The Trouble with Psychiatry*, SKEPTIC MAG., Sept. 22, 2007, at 37, 38–39 (explaining that there is not much “real evidence” to support the claim that psychiatric disorders can be explained through biology).

or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis.⁷¹

The danger of overreliance on the *DSM* comes into clearer focus with the expected May 2013 release of the *DSM-5*. To better understand this danger, Part III presents a primer on the changes to the ADA under the ADA Amendments Act of 2008 (“ADAAA”),⁷² with a focus on mental impairments. Part IV then describes the potentially dangerous interaction between the ADAAA and the *DSM-5*.

III. THE ADA AMENDMENTS ACT’S DANGEROUS INTERACTION WITH THE *DSM*

A. Key Changes in the ADAAA

On September 25, 2008, President George W. Bush signed the ADAAA into law.⁷³ The Act’s most significant changes affected the ADA’s treatment of what constitutes a “disability” and the ADA’s definitions of “substantial limitations,” “major life activities,” and “regarded as” disability. The ADAAA primarily addressed issues from two ADA-related U.S. Supreme Court cases: *Sutton v. United Air Lines*⁷⁴ and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*.⁷⁵

Sutton addressed disability discrimination claims made by two severely myopic plaintiffs who were denied employment for failing to satisfy minimum vision requirements based on uncorrected visual acuity.⁷⁶ The Court held that any measures that an individual takes to mitigate a physical or mental impairment must be considered when determining whether an individual is “disabled.”⁷⁷ Subsequent district and appellate court decisions relied on *Sutton* to find that some mental impairments did not constitute “disabilities” where they were adequately controlled by medication.⁷⁸

71. *DSM-IV*, *supra* note 1, at xxxiii.

72. See generally ADA Amendments Act of 2008, Pub. L. No. 110-325, § 8, 122 Stat. 3553 (codified at 42 U.S.C. §§ 12101–02, 12112, 12201, 12206, & 12211 (2006)) [hereinafter “ADAAA”].

73. *Id.* The Act took effect in January 2009.

74. 527 U.S. 471 (1999), *overturned by* ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008).

75. 534 U.S. 184 (2002), *overturned by* ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008).

76. *Sutton*, 527 U.S. at 475–76.

77. *Id.* at 482.

78. See, e.g., *Collins v. Prudential Inv. and Ret. Servs.*, 119 F. App’x 371, 378 (3d Cir. 2005) (noting that ADD/ADHD is not a “disability” when it is corrected through medication); *EEOC v. Rite Aid Corp.*, 750 F. Supp. 2d 564, 570–71 (D. Md. 2010) (same with epilepsy); *Burke v. Niagara Mohawk Power Corp.*, 142 F. App’x 527, 529 (2d Cir. 2005) (same with asthma).

Toyota considered whether an employer had failed to accommodate a claim by a plaintiff with carpal tunnel syndrome.⁷⁹ The Court held that an impairment must “prevent” or “severely restrict” a major life activity to constitute a “substantial limitation” on that activity,⁸⁰ and that a “major life activity” must be an activity “of central importance to daily life.”⁸¹ Prior to the Equal Employment Opportunity Commission’s (EEOC) publication of post-ADAAA regulations in March 2011,⁸² ADA regulations had narrowly defined terms like “substantially limits” as “unable to perform” a major life activity or “significantly restricted” in the performance of that activity.⁸³

The ADAAA also allowed Congress to resolve additional controversies raised by Court dicta, lower court decisions, and circuit splits among the appellate courts. Pre-ADAAA courts had divided over the issue of whether individuals covered under the ADA’s “regarded as” disabled prong were entitled to reasonable accommodations.⁸⁴ Appellate courts had also split over whether plaintiffs who claimed they were “regarded as” disabled also must prove that defendants had perceived those real or imagined disabilities as “substantially limiting.”⁸⁵

Pre-ADAAA Court law also required a mental (or physical) impairment to have a “permanent or long term” impact.⁸⁶ Accordingly, many district and circuit courts declined to find that an impairment substantially limited a plaintiff if the impairment was merely episodic or in remission.⁸⁷ Some courts went further and found that episodic or intermittent mental disorders did not constitute a “disability” under the

79. *Toyota*, 534 U.S. at 187.

80. *Id.* at 185. Some pre-ADAAA courts held or implied that plaintiffs must have been substantially limited in *more than one* major life activity to be considered “disabled” under the ADA. See, e.g., *Littleton v. Wal-Mart Stores, Inc.*, 231 F. App’x 874, 877 (11th Cir. 2007) (noting that the ability to drive a car might be inconsistent with an alleged disability affecting the major life activities of thinking and communicating); *Holt v. Grand Lake Mental Ctr., Inc.*, 443 F.3d 762, 766–67 (10th Cir. 2006) (finding a plaintiff with cerebral palsy as not “disabled” where she was not restricted in the ability to perform a “broad range of manual tasks”).

81. *Toyota*, 534 U.S. at 185.

82. Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, 29 C.F.R. §§ 1630.1–1630.16 (2012).

83. 29 C.F.R. § 1630.2(j)(1)(i)–(ii) (2002).

84. E.g., *D’Angelo v. ConAgra Foods, Inc.*, 422 F.3d 1220, 1235 (11th Cir. 2005) (discussing circuit split).

85. See, e.g., *Sutton v. United Air Lines*, 527 U.S. 471, 490–91 (1999).

86. *Toyota*, 534 U.S. at 185.

87. See, e.g., *EEOC v. Sara Lee Corp.*, 237 F.3d 349, 352 (4th Cir. 2001) (“To hold that a person is disabled whenever that individual suffers from an occasional manifestation of an illness would expand the contours of the ADA beyond all bounds.”).

ADA.⁸⁸

Pre-ADAAA courts often questioned whether “working” could qualify as a major life activity.⁸⁹ Although the regulations deemed “working” as a major life activity, they required plaintiffs to clear the significant hurdle of demonstrating that their impairments substantially limited their abilities to perform a “class of jobs” or a “broad range of jobs in various classes.”⁹⁰

B. Changes to the Legal Landscape in the ADAAA

1. “Disability”

The ADAAA rejected the *Sutton* Court’s holding, which required employers, under the ADA, to assess a “disability” in light of measures that mitigated mental (or physical) impairments.⁹¹ Instead, the Act required this assessment to be made without regard to the effects of mitigating measures.⁹² The ADAAA further clarified that an impairment need not substantially limit more than one major life activity to constitute a “disability.”⁹³ Importantly for mental illnesses, the Act provided that an episodic or intermittent impairment would still constitute a disability if it would substantially limit a major life activity when active.⁹⁴ Helpfully, Congress listed several examples of mitigating measures that must not be considered in determining whether a mental impairment constitutes a “disability,” including “medication” and “learned behavioral or adaptive neurological modifications.”⁹⁵

2. “Substantially Limits”

The ADAAA also rejected the *Toyota* Court’s holding that the ADA required an impairment to “prevent” or “severely restrict” a major life activity to constitute a “substantial limitation” on that activity.⁹⁶ The

88. See, e.g., *Rohan v. Networks Presentations LLC*, 375 F.3d 266, 276 (4th Cir. 2004) (noting that plaintiff with depression and PTSD was not substantially limited in interacting with others where PTSD flashback episodes were “sporadic and last[ed], at most, thirty minutes”).

89. See, e.g., *Toyota*, 534 U.S. at 200 (noting the “conceptual difficulties inherent in the argument that working could be a major life activity”); *Sutton*, 527 U.S. at 492 (noting that defining “major life activities” to include work may cause some conceptual difficulty).

90. 29 C.F.R. § 1630.2(j)(3)(i) (2002).

91. See generally ADAAA, § 8 (codified at 42 U.S.C. §§ 12101–02, 12112, 12201, 12206, & 12211 (2006)).

92. *Id.* § 2(b)(2). The ADAAA did grant exceptions for the effects of eyeglasses or contact lenses. See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(E)(ii)).

93. See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(C)).

94. See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(D)).

95. See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(E)(i)).

96. See *id.* § 2(b)(4).

Act also rejected the regulations' narrow definition of "substantially limits" as meaning "significantly restricted" in the performance of a major life activity.⁹⁷ Instead, the ADAAA specifically directed that the definition of "disability" be construed "in favor of broad coverage," consistent with the Act's findings and purposes.⁹⁸ Further clarifying Congress's intent to return the ADA to its original understanding, the Act's findings and purposes recited that the question of "whether an individual's impairment constitutes a disability should not demand extensive analysis."⁹⁹ The Act's findings and purposes also reflected Congress's expectation that the EEOC would revise the definition of "substantially limits."¹⁰⁰

3. "Major Life Activity"

Third, the ADAAA rejected *Toyota's* holding that a "major life activity" must be one of "central importance to most people's daily lives."¹⁰¹ Instead, the Act provided two non-exclusive lists of "major life activities"¹⁰²—one containing traditional activities that the EEOC's regulations previously recognized (plus a few activities only identified in court decisions and EEOC guidance),¹⁰³ and a second list of "major bodily functions," including "functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."¹⁰⁴ For individuals with mental impairments, Congress helpfully included multiple potentially relevant "major life activities" and "major bodily functions," including sleeping, concentrating, thinking, communicating, and neurological and brain functions.¹⁰⁵

4. "Regarded as" Disability

Finally, the ADAAA rejected federal courts' requirement that plaintiffs alleging "regarded as" disability prove that defendants perceived their real or imagined disabilities to be "substantially

97. *See id.* § 2(b)(6).

98. *See id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(A)–(B)).

99. *See id.* § 2(b)(5).

100. *See id.* § 2(b)(6).

101. *See id.* § 2(b)(4).

102. *See id.* § 4(a)(2) (codified at 42 U.S.C. § 12102(2)(A)–(B)) (listing the activities that constitute "major life activities").

103. Compare 29 C.F.R. § 1630.2(i) (2012), with ADAAA § 4(a)(2)(A) (codified at 42 U.S.C. § 12102(2)(A)) (listing activities such as performing manual tasks, seeing, hearing, and eating)). The ADAAA explicitly (and logically) recognized "working" as a major life activity. *Id.* § 4(a)(2)(A) (codified at 42 U.S.C. § 12102(2)(A)).

104. *See* ADAAA § 4(a)(2)(B) (codified at 42 U.S.C. § 12102(2)(B)).

105. *See id.* § 4(a)(2) (codified at 42 U.S.C. § 12102(2)(A)–(B)).

limiting.”¹⁰⁶ Instead, to satisfy this prong, the Act only required plaintiffs to prove that they suffered disability discrimination “because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.”¹⁰⁷ The ADAAA also provided that employers need not extend a reasonable accommodation to individuals who merely satisfy the “regarded as” definition of disability.¹⁰⁸

C. Effect of the ADAAA Regulations

For mental impairments, the ADAAA and its underlying revised regulations provide some different interpretations that changes to the *DSM-5* could potentially exploit. Most importantly, the ADA’s definition of “disability” after the ADAAA is to be construed broadly in favor of coverage and does not require “extensive analysis.”¹⁰⁹ Reinforcing the low bar for the initial steps, the regulations state that an impairment is a disability if it “substantially limits” the ability of an individual to perform a major life activity as compared to most people in the general population.¹¹⁰

The post-ADAAA regulations prescribe that an impairment that is episodic or in remission is a “disability” if it would substantially limit a major life activity when active.¹¹¹ This broader definition is critical to proposed *DSM-5* classifications of illnesses, such as Major Depressive Disorder, which include episodic events like bereavement. Even impairments with a brief duration can be “substantially limiting” under the revised regulations.¹¹² The regulations also provide a nonexclusive list of such potential impairments, including Major Depressive Disorder, Bipolar Disorder, and Post-Traumatic Stress Disorder, where it will “easily be concluded” that impairments limit a major life activity.¹¹³ The regulations also explicitly expand the list of major life activities, including the addition of “interacting with others.”¹¹⁴ This language establishes a presumption that many broad categories of mental impairments will meet both the disability and substantially limits prongs of the ADA analysis.

Additionally, the regulations state that mitigating measures are not to

106. See *id.* § 2(b)(3).

107. See *id.* § 4(a)(3)(A) (codified at 42 U.S.C. § 12102(3)(A)).

108. See *id.* § 6(a)(1)(h) (codified at 42 U.S.C. § 12201(h)).

109. 29 C.F.R. §§ 1630.1(c)(4), 1630.2(k)(2) (2012).

110. *Id.* § 1630.2(j)(1)(ii).

111. *Id.* § 1630.2(j)(1)(vii).

112. *Id.* § 1630.2(j)(1)(ix).

113. *Id.* § 1630.2(j)(3)(iii).

114. *Id.* § 1630.2(i)(1)(i).

be considered in determining disability.¹¹⁵ For mental impairments, this excludes the consideration of the effects of medication, learned or adaptive behaviors, or psychotherapy.¹¹⁶ An individual is “regarded as” having a disability if he is subjected to discrimination based on actual or perceived impairment, whether or not the impairment limits (or is perceived to limit) a major life activity.¹¹⁷ While an employer is not required to provide reasonable accommodations to individuals who are only “regarded as” disabled under the ADA,¹¹⁸ the post-ADAAA regulations add that “regarded as” disability discrimination may arise from adverse employment actions taken based on the symptoms of actual or perceived impairments, or on medication used to treat such impairments.¹¹⁹

IV. BROADENING DEFINITIONS: THE PROPOSED *DSM-5*

A. *Medical Community Criticisms of the DSM-5*

After publishing text revisions to the *DSM-IV* in 2000, the APA began preparing for the development of the *DSM-5*.¹²⁰ Just as the *DSM-IV* received criticism during its development,¹²¹ word of the *DSM-5* was met with considerable opposition from various medical and nonmedical groups almost from the outset of the project. For example, psychiatrist Paul Chodoff sarcastically suggested in the APA’s *Psychiatric News* that the *DSM-5* should adopt his proposed diagnosis of “the human condition.”¹²² With “diagnostic criteria” that included disliking school, fidgeting, disobedience (for children), dissatisfaction with one’s sexual performance, unhappiness, shyness, getting angry, and playing the horses (for adults), Dr. Chodoff cynically wrote that this diagnosis would “encourage the quest for a drug to cure the disorder of being human.”¹²³ His comments underscored the psychiatric community’s unease with the ever-expanding *DSM*.

Even the confidentiality agreement that the Association required

115. *Id.* § 1630.2(j)(1)(vi).

116. *Id.* § 1630.2(j)(5)(i), (iv)–(v).

117. *Id.* § 1630.2(l)(1).

118. *Id.* § 1630.9(e).

119. *Id.* § 1630.2(l)(1).

120. *See DSM-5 Publication Date Moved to May 2013*, *supra* note 2 (noting that the APA will publish a new edition of the *DSM* for the first time in twenty years in May 2013).

121. *See supra* note 34 (citing scholarly critics of the *DSM-IV*, particularly in regards to the diagnostic categories).

122. Dr. Paul Chodoff, *Letter to the Editor: Proposed Diagnosis*, *PSYCHIATRIC NEWS* (Jan. 21, 2005), <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=108472>.

123. *Id.*

DSM-5 Work Group and Task Force members to sign could not escape controversy. The agreement prohibited the disclosure of any written or unwritten information, including notes and discussions, relating to the members' work on the *DSM-5*.¹²⁴ In 2009, Robert Spitzer and Allen Frances, the Task Force chairs for the *DSM-III* and *DSM-IV*, respectively, excoriated the APA's Board of Trustees in an open letter for allowing the *DSM-5* leadership to "seal[] itself off from advice and criticism" and engage in a "secretive and closed DSM process" that "cannot function properly."¹²⁵

Spitzer and Frances's real fear, however, was the lack of quality control in the *DSM-5* process that was already spawning "damaging public controversies."¹²⁶ Their 2009 letter warned that the *DSM-5* leadership had been "insensitive to the great risks of false positives, of medicalizing normality, and of trivializing the whole concept of psychiatric diagnosis."¹²⁷ Frances later warned that the *DSM-5*'s proposals could amount to a "wholesale medical imperialism of normality [that] could potentially create tens of millions of innocent bystanders who would be mislabeled as having a mental disorder."¹²⁸ Other commentators cautioned that "diagnosis informs treatment decisions," and that even "small changes in symptom criteria" could have "significant impacts" on treatment.¹²⁹ Shortly after the publication of Spitzer and Frances's letter, the APA pushed the *DSM-5*'s original 2012 publication date back to May 2013, ostensibly to more closely coincide with the release of the *ICD-10-CM* ("Clinical Modification"), which is due in October 2013.¹³⁰ The delay did little to change the direction of the *DSM-5* or the wealth of medical community criticism.

124. Robert L. Spitzer, *DSM-V Transparency: Fact or Rhetoric?*, PSYCHIATRIC TIMES (Mar. 6, 2009), <http://www.psychiatristimes.com/display/article/10168/1385346>. The Association responded that the agreement was designed to avoid "premature conclusion and misconceptions . . . that could damage the viability of DSM-V." Nada L. Stotland et al., *DSM-V: Open and Transparent?: Response*, PSYCHIATRIC NEWS (July 18, 2008), <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=111946>.

125. Letter from Allen Frances & Robert Spitzer to the Am. Psychiatric Ass'n Bd. of Trs. (July 6, 2009), available at <http://www.scribd.com/doc/17172432/Letter-to-APA-Board-of-Trustees-July-7-2009-From-Allen-Frances-and-Robert-Spitzer>.

126. *Id.*

127. *Id.*

128. Allen Frances, *It's Not Too Late to Save 'Normal,'* L.A. TIMES, Mar. 1, 2010, <http://articles.latimes.com/2010/mar/01/opinion/la-oe-frances1-2010mar01> [hereinafter Frances, *It's Not Too Late*].

129. Lisa Cosgrove & Harold J. Bursztajn, *Toward Credible Conflict of Interest Policies in Clinical Psychiatry*, PSYCHIATRIC TIMES (Jan. 1, 2009), <http://www.psychiatristimes.com/display/article/10168/1364672>.

130. See *DSM-5 Publication Date Moved to May 2013*, *supra* note 2 (noting the planned publication of the *DSM-5* in May 2013).

The delay and ongoing debate should have raised red flags for legal practitioners.¹³¹

In June 2011, the British Psychological Society lodged a highly critical response to the proposed revisions,¹³² one that a host of other prominent psychological organizations and psychologists later adopted in an open online petition.¹³³ The Society joined Spitzer and Frances's earlier criticism that the general public was "negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences; responses which undoubtedly have distressing consequences which demand helping responses, but which do not reflect illnesses so much as normal individual variation."¹³⁴ The Society warned that many of the putative diagnoses presented in *DSM-5* were "clearly based largely on social norms, with 'symptoms' that all rely on subjective judgments, with little confirmatory physical 'signs' or evidence of biological causation."¹³⁵ Like Spitzer and Frances, the Society saw a need for "a revision of the way mental distress is thought about, starting with recognition of the overwhelming evidence that it is on a spectrum with 'normal' experience," influenced by causal factors such as poverty, unemployment, and trauma.¹³⁶ The Society recommended that an ideal classification system should not be based on "preordained diagnostic categories" but rather should "begin from the bottom up—starting with specific experiences, problems or 'symptoms' or 'complaints.'"¹³⁷

Amid the furor, Dr. William Narrow, the *DSM-5* Task Force's Research Director, responded to some of the criticisms in an interview with the *Pittsburgh Post-Gazette*.¹³⁸ However, his question-and-answer

131. Indeed, it was the *DSM-5* Task Force's announcement of the delayed publication that first brought the disputes about the *DSM-5* to my attention and the attention of my then-colleagues at the Social Security Administration's Office of the General Counsel, the office tasked with defending the agency's disability determinations on appeal.

132. BRITISH PSYCHOLOGICAL SOC'Y, RESPONSE TO THE AMERICAN PSYCHIATRIC ASSOCIATION: DSM-5 DEVELOPMENT (2011), available at http://apps.bps.org.uk/_publication/files/consultation-responses/DSM-5%202011%20-%20BPS%20response.pdf. The Society published an updated response in June 2012. BRITISH PSYCHOLOGICAL SOC'Y, DSM-5: THE FUTURE OF PSYCHIATRIC DIAGNOSIS (2012–FINAL CONSULTATION): BRITISH PSYCHOLOGICAL SOCIETY RESPONSE TO THE AMERICAN PSYCHIATRIC ASSOCIATION (June 2012).

133. *Open Letter to the DSM-5*, IPETITIONS.COM, <http://www.ipetitions.com/petition/dsm5/> (last visited Oct. 22, 2011).

134. RESPONSE TO THE AMERICAN PSYCHIATRIC ASSOCIATION: DSM-5 DEVELOPMENT, *supra* note 132, at 2.

135. *Id.*

136. *Id.* at 3.

137. *Id.*

138. Q&A with Dr. William Narrow, Research Director for the DSM 5 Task Force, PITTSBURGH POST-GAZETTE (Jan. 30, 2012), <http://www.post-gazette.com/stories/news/health/>

session with the newspaper only served to raise more red flags for *DSM-5* critics and legal practitioners.¹³⁹ Dr. Narrow explained that the *DSM-5* was necessary because the *DSM-IV*, completed nearly twenty years ago, was “no longer considered up-to-date.”¹⁴⁰ In response to ongoing criticism about the expansion of the *DSM-5* and the fear that it would lead to the medicalization of normal experiences and the overdiagnosis of mental disorders, Dr. Narrow responded that the *DSM-5* Task Force had been vetting draft proposals against scientific findings and field testing. He added that the Task Force had been focusing the *DSM-5* to address “concerns” that the *DSM-IV* was too “biologically focused”¹⁴¹—oddly the polar opposite of major criticisms from the medical field and major media.¹⁴² Unsurprisingly for lawyers, Dr. Narrow responded with an entirely clinical focus to the *DSM-5* criticism, not a legal one.¹⁴³ Dr. Narrow’s response demonstrates that not only will medical professionals have to live with the *DSM-5* (for better or for worse), but so too will legal practitioners. Members of the legal academy who have been invited to participate in the development of the *DSM-5* have expressed alarm and concern at some of the “vague and unscientific” proposed modifications.¹⁴⁴ Unfortunately, legal

qa-with-dr-william-narrow-research-director-for-the-dsm-5-task-force-219825.

139. See, e.g., Martha J. Zackin, *Psychiatric Disabilities under the ADA: Proposed Changes to Diagnostic Tool May Result in a Broader Definition of “Disability,”* LABOR & EMP’T COMMENTARY BLOG (Nov. 17, 2011), <http://www.lexisnexis.com/community/labor-employment-law/blogs/labor-employment-commentary/archive/2011/11/17/psychiatric-disabilities-under-the-ada-proposed-changes-to-diagnostic-tool-may-result-in-a-broader-definition-of-quot-disability-quot.aspx>; Daniel Schwartz, *With DSM-5 on the Way, Is It Time to Update Definition of “Mental Disability”?*, CONN. EMP’T BLOG (Feb. 21, 2012), <http://www.ctemploymentlawblog.com/2012/02/articles/with-dsm-5-on-the-way-is-it-time-to-update-definition-of-mental-disability/> (warning that Connecticut has specifically adopted the *DSM* definitions); Douglas A. Hass & Lisa McGarrity, *Could the American Psychiatric Association Cause Employers Headaches? The Potential Impact of the DSM-5*, FRANCZEK RADELET (Mar. 1, 2012), http://www.franczek.com/frontcenter-American_Psychiatric_Association_Impact_DSM-5.html (providing a legal update to firm clients regarding the impending *DSM-5* release).

140. Q&A with Dr. William Narrow, *supra* note 138.

141. *Id.*

142. See *supra* notes 122–37 and accompanying text.

143. See, e.g., Benedict Carey, *Revising Book on Disorders of the Mind*, N.Y. TIMES, Feb. 10, 2010, at A1 (stating that the modifications to the *DSM-5* have effects in fields other than psychiatry, such as the legal and pharmaceutical fields).

144. See generally RUTH COLKER ET AL., COMMENTS ON PROPOSED DSM-5 CRITERIA FOR SPECIFIC LEARNING DISORDER FROM A LEGAL AND MEDICAL/SCIENTIFIC PERSPECTIVE, available at <http://dyslexia.yale.edu/CommentsDSM5ColkerShaywitzSimon.pdf> (recommending that the *DSM-5* Task Force reverse its planned elimination of Dyslexia in favor of “Specific Learning Disorder”); Ruth Colker, *Guest Post: Learning Disability DSM-5 Mess*, LEXERCISE (June 1, 2012), <http://www.lexercise.com/2012/06/learning-disability-dsm-5-mess/> (stating that the proposed removal of dyslexia in favor of the “vague and unscientific term ‘Specific Learning

practitioners will have far less input into its development than practicing doctors.

An editorial by Til Wykes and Felicity Callard, from King's College London, neatly summarized the problems with the proposed revisions for the *DSM-5*:

The current release for public consideration includes proposals for new diagnoses—including mixed anxiety depression, binge eating, psychosis risk syndrome and temper dysregulation disorder with dysphoria—where the symptoms are shared with the general population. It is also proposed that the threshold for inclusion for some existing disorders be lowered, and a few (but not many) diagnoses are scheduled for removal. Most of these changes imply a more inclusive system of diagnoses where the pool of “normality” shrinks to a mere puddle.¹⁴⁵

Several proposals not only risk misuse and overdiagnosis in various populations, but also create legal concerns. The *DSM-5*'s proposals, as well as other formal disorders currently under consideration by the APA, could directly impact whether employees can bring claims under the ADA (regarding claims of “disability” and requests for reasonable accommodations), the FMLA (concerning definitions of a “serious illness”), and even the ADEA and workers' compensation laws (questioning whether an illness is work related).

B. Legal Difficulties Presented by the DSM-5's Proposed Changes

Against the backdrop of the medical community criticisms, proposed changes in the *DSM-5* would medicalize as disorders a number of potentially work-related conditions that previous editions have never identified. Official recognition of a disorder in the *DSM-5* leads directly¹⁴⁶ or indirectly to recognition of that disorder in claims made pursuant to the ADA, the FMLA, workers' compensation, and other federal or state employment laws. Among the troubling new definitions that the APA has proposed adding as formal disorders are Attenuated Psychosis Syndrome,¹⁴⁷ Mild Neurocognitive Disorder,¹⁴⁸ Social

Disorder” was “alarming” and could cause “tens of thousands” of individuals to lose disability classifications). Professor Colker is a Distinguished University Professor and the Heck-Faust Memorial Chair in Constitutional Law at The Ohio State University Moritz College of Law.

145. Til Wykes & Felicity Callard, *Diagnosis, Diagnosis, Diagnosis: Towards DSM-5*, 19 J. MENTAL HEALTH 301, 302 (2010).

146. For example, Connecticut statutes explicitly refer to mental disorders as defined in “the most recent edition of the American Psychiatric Association's ‘Diagnostic and Statistical Manual of Mental Disorders.’” E.g., CONN. GEN. STAT. §§ 4a-60(d), 38a-488a, 53a-181i (2012).

147. *Attenuated Psychosis Syndrome*, AM. PSYCHOLOGICAL ASS'N, <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=412> (last visited Sept. 27, 2012). See also APA Approves *DSM-5*, *supra* note 5, at 2 (listing Attenuated Psychosis Syndrome).

Communication Disorder,¹⁴⁹ and Callous and Unemotional Specifier for Conduct Disorder.¹⁵⁰ Other changes slated for *DSM-5* include significant modifications to existing disorders, such as Major Depressive Disorder¹⁵¹ and Generalized Anxiety Disorder.¹⁵² The APA is also considering the addition of other questionably supportable disorders that were suggested by outside sources, such as Apathy Syndrome, Internet Addiction Disorder, and Seasonal Affective Disorder.¹⁵³

1. Attenuated Psychosis Syndrome

One of the most contentious new disorders of the new *DSM-5* is Attenuated Psychosis Syndrome, a proposal that would greatly expand the universe of psychotic disorders officially recognized by the *DSM*. Under the proposed definition, Attenuated Psychosis Syndrome would consist of a combination of low-level psychotic symptoms, distress, and social dysfunction that could occur as infrequently as once a week, as long as the *patient* views them as “sufficiently distressing and disabling . . . to lead them to seek help.”¹⁵⁴ In an early 2012 interview, Dr. Narrow indicated that the APA had estimated that nearly 80% of potential “attenuated psychosis syndrome” patients go undiagnosed under the *DSM-IV*.¹⁵⁵ Official recognition of this new disorder could lead more employees to claim that normal, job-related stress has led to a *DSM*-recognized mental disorder. With the ADAAA lowering the bar

148. *S 03 Mild Neurocognitive Disorder*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=420> (last visited Sept. 27, 2012).

149. *A 04 Social Communication Disorder*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=489> (last visited Sept. 27, 2012).

150. *Q 02.1 Callous and Unemotional Specifier for Conduct Disorder*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=424> (last visited Sept. 27, 2012).

151. *D 01 Major Depressive Disorder, Single Episode*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=44> (last visited April 2012); *D 02 Major Depressive Disorder, Recurrent*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=45> (last visited Sept. 27, 2012).

152. *E 05 Generalized Anxiety Disorder*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=167> (last visited Sept. 27, 2012).

153. *Conditions Proposed by Outside Sources*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/proposedrevisions/pages/conditionsproposedbyoutsidesources.aspx> (last visited Sept. 27, 2012). See also APA Approves *DSM-5*, *supra* note 5, at 2 (listing Internet Addiction Disorder).

154. *Attenuated Psychosis Syndrome*, *supra* note 147. Under the proposed definition, either practitioners or patients can document the existence of these symptoms. *Id.*

155. See *Q&A with Dr. William Narrow*, *supra* note 138 (advocating that formal recognition of Attenuated Psychosis Syndrome under *DSM-5* “would mean a greater likelihood that clinicians will recognize the syndrome . . . and be able to follow the symptoms over time and intervene when needed”).

for what constitutes a “disability” or what “substantially limits” a major life activity, employees would receive significantly more protection under the ADA, the FMLA, state workers compensation laws, and other employment laws.

To the APA’s credit, its most recent revisions after its third public comment period ending in June 2012 delayed the formal identification of two other disorders with employment-related concerns: Attenuated Psychosis Syndrome and Mixed Anxiety Depressive Disorder.¹⁵⁶ In its final pre-publication update posted to the *DSM-5* website, the Task Force recommended these conditions “for further study,” noting that they “require further research” before consideration as formal disorders.”¹⁵⁷

2. Mild Neurocognitive Disorder

Among the most troubling proposed changes to the *DSM-5* is the addition of “Mild Neurocognitive Disorder.” Grouped with delirium, dementia, amnesia, and other cognitive disorders,¹⁵⁸ the proposed *DSM-5* defines Mild Neurocognitive Disorder as involving a “modest cognitive decline from a previous level of performance”—in other words, a modest decline in memory—not otherwise associated with another mental disorder, such as Delirium or Major Depressive Disorder.¹⁵⁹ According to the proposed revision, Mild Neurocognitive Disorder does not interfere with a person’s independence or activities of daily living (including complex tasks), but “greater effort, compensatory strategies, or accommodation may be required to maintain independence.”¹⁶⁰ Notably, the only “evidence” required for this diagnosis is the self-reported “[c]oncerns of the individual” or “a knowledgeable informant.”¹⁶¹

DSM-5 critics have rightly argued that this definition is unacceptably

156. Attenuated Psychosis Syndrome, originally named Psychosis Risk Syndrome, is primarily diagnosed in adolescents and young adults, so its implications in the employment context may be limited. For a discussion of the issues raised by the possible identification of this disorder, see Allen Frances, *Psychosis Risk Syndrome: Just as Risky with a New Name*, PSYCHOL. TODAY, July 30, 2010, and Johnathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL’Y 181, 249–53 & nn.432–53 (2012).

157. See, e.g., *Attenuated Psychosis Syndrome (Proposed for Section III of the DSM-5)*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/proposedrevision/Pages/proposedrevision.aspx?rid=412> (last visited Sept. 27, 2012).

158. See *Neurocognitive Disorders*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/ProposedRevision/Pages/NeurocognitiveDisorders.aspx> (last visited Sept. 27, 2012).

159. See *S 03 Mild Neurocognitive Disorder*, *supra* note 148.

160. *Id.*

161. *Id.*

broad. Allen Frances, for one, listed Mild Neurocognitive Disorder as one of the “19 worst suggestions” for the *DSM-5*.¹⁶² He argues that adding Mild Neurocognitive Disorder risks medicalizing predictable cognitive declines of aging.¹⁶³ Nonspecific symptoms, such as a modest cognitive decline from a previous level of performance, are “very common (perhaps almost ubiquitous) in people over fifty.”¹⁶⁴ This definition creates the potential for millions of individuals, who will never develop dementia, to receive a diagnosis (or misdiagnosis) of Mild Neurocognitive Disorder.¹⁶⁵ Although diagnosis nominally requires an objective cognitive assessment, even the *DSM-5*’s Neurocognitive Disorders Work Group recognized that truly objective clinical assessments may be problematic.¹⁶⁶ Frances argues that even if primary care physicians do not ignore the need for a formal neurological assessment, such assessments would do little to prevent false positives, if, as now, it is designed to include more than 13% of the population.¹⁶⁷

The problems with misdiagnosis of Mild Neurocognitive Disorder extend beyond the medical context and into the employment relationship. In distinguishing ADA and ADEA claims, the Seventh Circuit cautioned that old age “does not define a discrete and insular minority because all persons, if they live out their normal life spans, will experience it.”¹⁶⁸ The ADEA protects older employees from discrimination, but the ADEA “does not include any additional considerations for identifying ‘qualified individuals’ that might be analogized to the ‘reasonable accommodation’ language of the ADA.”¹⁶⁹ However, the ADA carries with it a duty to provide a reasonable accommodation for a disability. Older employees with some expected, age-related decline in cognitive performance could begin claiming job-related accommodations for these cognitive deficits using

162. Allen Frances, *Opening Pandora’s Box: The 19 Worst Suggestions for DSM5*, PSYCHIATRIC TIMES (Feb. 11, 2010), <http://www.psychiatristimes.com/dsm/content/article/10168/1522341> [hereinafter Frances, *Opening Pandora’s Box*].

163. *Id.*

164. *Id.*

165. *Id.*

166. See *S 03 Mild Neurocognitive Disorder*, *supra* note 148 (“[S]ymptom reports may be unavailable or unreliable, observation may be less informative, the interpretation of objective assessments is complicated by variable premorbid abilities, and simpler assessments are likely to be insensitive.”).

167. See Frances, *Opening Pandora’s Box*, *supra* note 162 (“[G]etting a meaningful reference point is impossible in most instances and the threshold has been set to include a whopping 13.5% of the population . . .”).

168. *Erickson v. Bd. of Governors of State Colls. & Univs. for N.E. Ill. Univ.*, 207 F.3d 945, 950, (7th Cir. 2000) (quoting *Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 83 (2000)).

169. *Detz v. Greiner Indus., Inc.*, 346 F.3d 109, 117 (3d Cir. 2003).

the *DSM-5*'s Mild Neurocognitive Disorder, thereby transforming their ADEA claims into ones under the ADA and pursuing redress for a phenomenon that all individuals could eventually experience.

As discussed above, the ADAAA has already lowered the bar for what constitutes a "disability" or what "substantially limits" a major life activity. The proposed Mild Neurocognitive Disorder definition included the key phrase that "accommodation may be required."¹⁷⁰ While commentators have rightly argued that the ADEA has failed to address the continued emergence of ageist stereotypes and associated discrimination,¹⁷¹ the "remedy" of pushing (eventually) every employee and employer through the ADA interactive process by default would create obvious administrative and logistical nightmares for both parties.

3. Social Communication Disorder

Another puzzling proposed addition to the *DSM-5* is "Social Communication Disorder."¹⁷² Categorized as a neurodevelopment disorder with language and speech disorders like ADHD, autism, and Tourette Syndrome,¹⁷³ the proposed *DSM-5* defines Social Communication Disorder as "low social communication abilities result[ing] in functional limitations in effective communication, social participation, academic achievement, or occupational performance, alone or in any combination."¹⁷⁴ Another one of the diagnostic criteria suggests that people with ongoing difficulties in verbal and nonverbal communication that affect the "development of social reciprocity and social relationships" meet the *DSM-5* proposed definition.¹⁷⁵ While this definition may fit individuals with forms of autism who otherwise fall short of the *DSM* diagnostic criteria for Autism Spectrum Disorder, the *DSM* Task Force defined it so broadly that it could also match just about any of the "geeks, sportos, motorheads, dweebs, dorks, sluts, buttheads"¹⁷⁶ or other individuals in a workplace who might struggle to fit in due to their particular eccentricities. With the lowered ADAAA

170. *S 03 Mild Neurocognitive Disorder*, *supra* note 148.

171. See, e.g., Judith J. Johnson, *Reasonable Factors Other than Age: The Emerging Specter of Ageist Stereotypes*, 33 SEATTLE U. L. REV. 49, 49 (2009) (arguing that because courts, including the Supreme Court, are allowing employers "to interpose defenses that correlate so strongly with age that they can be used as thinly veiled covers for discrimination," the protections afforded under the ADEA are still in danger despite attempts at reform).

172. *04 Social Communication Disorder*, *supra* note 149.

173. See *Neurodevelopmental Disorders*, AM. PSYCHOLOGICAL ASS'N, <http://www.dsm5.org/ProposedRevision/Pages/NeurodevelopmentalDisorders.aspx> (last visited Sept. 27, 2012).

174. *04 Social Communication Disorder*, *supra* note 149.

175. *Id.*

176. *FERRIS BUELLER'S DAY OFF* (Paramount Pictures 1986) (Grace, Principal Ed Rooney's secretary, explaining to Rooney why everyone thought Ferris was a "righteous dude").

bar, tens of thousands of employees and their employers could potentially and unnecessarily face the ADA interactive process (or decline to do so at great expense).¹⁷⁷ Despite the above reference to a classic '80s film,¹⁷⁸ the concern about employees who do not "fit in" is not a trivial one in the workplace. The management-side labor and employment law firm where I practice¹⁷⁹ represents many employers who have specifically expressed concerns about managing employees with eccentricities and quirks. Adding the possibility of an ADA discrimination claim to the mix of a harassment investigation, a routine disciplinary matter, or other employment issue unnecessarily complicates the employer/employee relationship at best, and leads to a parade of horrors for both employee and employer at worst.

4. Callous and Unemotional Specifier for Conduct Disorder

Another proposed addition to the *DSM-5* is the obtusely named "Callous and Unemotional Specifier for Conduct Disorder."¹⁸⁰ The proposed *DSM-5* lists this new disorder among disruptive, impulse control, and conduct disorders such as Oppositional Defiant Disorder and Intermittent Explosive Disorder.¹⁸¹ To meet the diagnostic criteria, an individual need only fail to "show concern about poor/problematic performance at school, work, or in other important activities" and seem "shallow, insincere, or superficial."¹⁸² As with Social Communication Disorder, Callous and Unemotional Specifier for Conduct Disorder would medicalize what others categorize as part of the human condition.¹⁸³ Conceivably, an employer that places an employee on a performance improvement plan because of the employee's failure to correct deficient job performance could be met with threats of an ADA discrimination claim. Again, using the *DSM-5* as support, the focus of a performance plan could easily shift from rebuilding a successful employee/employer relationship to negotiating the employee's exit, or worse.

177. See generally Walter Olson, *Revised DSM-5 Could Open Up Wider Legal Claims*, CATO INST. (Dec. 5, 2011), <http://www.cato-at-liberty.org/revised-dsm-5-could-open-up-wider-legal-claims/> (highlighting some of the "serious legal risks" that employers face).

178. See FERRIS BUELLER'S DAY OFF, *supra* note 176.

179. FRANCZEK RADELET, P.C., <http://www.franczek.com/> (last visited Feb. 13, 2013).

180. Q 02.1 *Callous and Unemotional Specifier for Conduct Disorder*, *supra* note 150.

181. See *DSM-5, Disruptive, Impulse Control, and Conduct Disorders*, AM. PSYCHOLOGICAL ASS'N, <http://www.dsm5.org/ProposedRevision/Pages/Disruptive,ImpulseControl,andConductDisorders.aspx> (last visited Sept. 27, 2012).

182. Q 02.1 *Callous and Unemotional Specifier for Conduct Disorder*, *supra* note 150.

183. See *supra* notes 122–23 and accompanying text (providing satirical commentary on medicalization of the human condition).

5. Modifications to Major Depressive Disorder and Generalized Anxiety Disorder

The *DSM-5*'s changes are not limited to the addition of disorders that skeptical courts could dismiss or ignore. The APA's Board of Trustees has approved the removal of the implicit "bereavement exclusion" from the diagnostic definition of Major Depressive Disorder, a disorder that consists of one or more Major Depressive Episodes.¹⁸⁴ The *DSM-IV*'s definition of Major Depressive Episode¹⁸⁵ specifically exempted bereavement or other events involving a significant loss, even when symptoms lasted the requisite two weeks.¹⁸⁶ The *DSM-5*'s proposed criteria, however, reversed this definition, explicitly stating that the "normal and expected response to an event involving significant loss (e.g., bereavement, financial ruin, or natural disaster) may resemble a depressive episode," and when combined with symptoms of other functional impairments "suggest the presence of a Major Depressive Episode."¹⁸⁷

Under this new definition, individuals whose grief, a normal life process, resembles a major depressive episode (e.g., two weeks of symptoms such as a depressed mood, loss of appetite, fatigue, trouble thinking or concentrating, insomnia, and loss of interest in or pleasure from activities) immediately after a major financial loss or the death of a loved one would be properly diagnosed with Major Depressive Disorder.¹⁸⁸

This significant change will likely increase the diagnosis of Major Depressive Disorder and medicalize normal grief.¹⁸⁹ Allen Frances labeled this change another of the "19 worst" in the *DSM-5*.¹⁹⁰ From a legal standpoint, the *DSM-5*'s transformation of grief into a diagnosable mental illness means that employers' "bereavement leave" policies may no longer suffice. Instead, employers and employees could again be forced through the ADA interactive process, FMLA leave discussions,

184. See APA Approves *DSM-5*, *supra* note 5, at 4 (announcing that the bereavement exclusion "has been removed and replaced by several notes within the text delineating the differences between grief and depression"). See also sources cited *supra* note 151 (discussing Major Depressive Disorder).

185. See *Major Depressive Episode*, AM. PSYCHOLOGICAL ASS'N, <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=427> (last visited Sept. 27, 2012).

186. *Id.*

187. *Id.*

188. *Id.*

189. Frances, *Opening Pandora's Box*, *supra* note 162.

190. See *id.* ("This is radical and astounding change that may be helpful for some individuals, but will cause a huge false positive problem—especially since there is so much individual and cultural variability in bereavement. Of course, grief would become an extremely inviting target for the drug companies.").

and other unnecessary legal discussions.

Another suggested change in the *DSM-5* is to the definition of Generalized Anxiety Disorder.¹⁹¹ While the general criteria—restlessness, anxiety and worry, distress, and impairment of social functioning—remain largely unchanged, the proposed *DSM-5* lowers the threshold of these symptoms for diagnosis.¹⁹² First, the *DSM-5* reduces the required duration of these symptoms to just three months.¹⁹³ Second, the *DSM-5* proposal reduces the number of different associated behaviors required for diagnosis.¹⁹⁴ Under the *DSM-IV*, patients needed to exhibit three out of the following six behaviors: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbance.¹⁹⁵ The *DSM-5* proposal requires that patients only show either restlessness or muscle tension, and one of the following conditions: avoidance of activities, excessive time and effort to prepare for activities, procrastination, or seeking reassurance from others due to worries.¹⁹⁶ Critics have characterized the rationale for these “radical changes” as “completely unconvincing” and “remarkably thin.”¹⁹⁷ The proposed criteria not only significantly lower the diagnostic threshold for Generalized Anxiety Disorder, but the *DSM-5*’s revised list of symptoms seems difficult to distinguish from the normal anxieties of everyday life. As with the confirmed removal of the bereavement exclusion, the *DSM-5*’s proposed identification of these everyday anxieties as a mental disorder would also force employers and employees into the ADA interactive process, FMLA leave discussions, and other lengthy and unnecessary legal discussions.

6. Outside Proposals under Consideration for the *DSM-5*

The *DSM-5* has also proposed a significant change to the definition of a Mental Disorder to remove the *DSM-IV*’s exclusion of both deviant (e.g., political, religious, or sexual) behavior and primary conflicts between the individual and society from the definition.¹⁹⁸ The *DSM-IV*

191. See *E 05 Generalized Anxiety Disorder*, *supra* note 152.

192. See *id.* (providing *DSM-5* and *DSM-IV* definitions of Generalized Anxiety Disorder).

193. Dr. Frances notes that the original proposal lowered the threshold to just one month. Allen Frances, *DSM 5 Will Medicalize Everyday Worries into Generalized Anxiety Disorder: An Example of Sloppy DSM 5 Methods*, PSYCHOL. TODAY (Apr. 12, 2011), <http://www.psychologytoday.com/blog/dsm5-in-distress/201104/dsm-5-will-medicalize-everyday-worries-generalized-anxiety-disorder> [hereinafter Frances, *Generalized Anxiety Disorder*]

194. See *E 05 Generalized Anxiety Disorder*, *supra* note 152.

195. *Id.*

196. *Id.*

197. See, e.g., Frances, *Generalized Anxiety Disorder*, *supra* note 193.

198. See *Definition of a Mental Disorder*, AM. PSYCHOLOGICAL ASS’N, <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=465> (last visited Sept. 27, 2012).

logically excluded deviance and conflict from the definition, except to the extent they were symptoms of another, diagnosable dysfunction.¹⁹⁹

In contrast, the proposed *DSM-5* suggests that a mental disorder *can* be the result of these factors, so long as they are not “primarily” the cause.²⁰⁰ Medical critics have observed that the lack of consensus as to the “primary” causes of mental distress could result in practitioners classifying sociopolitical deviance as a mental disorder.²⁰¹ In most jurisdictions, political affiliation is not a protected class; a private employer can, in most cases, make employment decisions based on an employee’s political affiliation.²⁰² However, if holding radical sociopolitical philosophy beliefs can establish a mental health disorder, then a Neopaganist²⁰³ could claim that his pro-racist, pro-Nazi beliefs are part of a mental health disorder and seek protection under the ADA.²⁰⁴

In recent years, news reports have highlighted a British poll²⁰⁵ and an American Academy of Pediatrics report in the journal *Pediatrics*²⁰⁶ that discussed the empirically questionable “Internet Addiction Disorder.” Internet Addiction Disorder was originally proposed as a satirical hoax

199. *Id.* (providing *DSM-IV* definition).

200. *Id.* (using the same definition, but inserting the modifier “primarily”).

201. See *Open Letter to the DSM-5*, *supra* note 133 and accompanying text. The Open Letter addressed this deviant behavior change in detail:

Taken literally, *DSM-5*’s version suggests that mental disorder may be the result of these factors so long as they are not “primarily” the cause. In other words, this change will require the clinician to draw on subjective etiological theory to make a judgment about the cause of presenting problems. It will further require the clinician to make a hierarchical decision about the primacy of these causal factors, which will then (partially) determine whether mental disorder is said to be present. Given lack of consensus as to the “primary” causes of mental distress, this proposed change may result in the labeling of sociopolitical deviance as mental disorder.

Id.

202. See, e.g., Ill. Human Rights Act, 775 ILCS 5/1-102 (2012) (defining protected classes); Mass. Gen. Laws c. 151B, § 4 (same). See also, e.g., *Nguyen v. Univ. of Mass.*, 846 N.E.2d 1184, 1188 (Mass. Ct. App. 2006) (“[Massachusetts laws] do not provide protection for political beliefs.”).

203. See generally HELEN A. BERGER, WITCHCRAFT AND MAGIC: CONTEMPORARY NORTH AMERICA 4, 45–54 (2006) (discussing neopaganism and its pro-racist and pro-Nazi sects).

204. In theory, this definition could stretch further to “Birthers,” conspiracy theorists, Holocaust deniers, or any manner of sociopolitical beliefs outside the “mainstream.”

205. John Joseph, *Nearly Half of Britons Suffer “Discomgoogolation,”* REUTERS (Sept. 1, 2008), <http://uk.reuters.com/article/2008/09/01/us-britain-internet-idUKL146220120080901> (discussing a poll that “found 76 percent of Britons could not live without the Internet, with over half of the population using the web between one and four hours a day and 19 percent of people spending more time online than with their family in a week”).

206. Gwenn Schurgin O’Keeffe & Kathleen Clarke-Pearson, *Clinical Report—The Impact of Social Media on Children, Adolescents, and Families*, 127 PEDIATRICS 800 (2011), available at <http://pediatrics.aappublications.org/content/early/2011/03/28/peds.2011-0054.full.pdf+html>.

by Dr. Ivan Goldberg in 1995, modeled after the *DSM-IV*'s diagnostic criteria for pathological gambling.²⁰⁷ Despite the general lack of support in medical studies for this addiction,²⁰⁸ the APA is nonetheless considering adding the disorder category to the *DSM-5*.²⁰⁹

As discussed above, the APA is also considering, or has explicitly approved, the addition of conditions that outside sources suggested—such as “Apathy Syndrome,” “Internet Addiction,” and “Seasonal Affective Disorder”—as psychiatric disorders for further study.²¹⁰ Medical literature defines apathy syndrome as “a syndrome of primary motivational loss, that is, loss of motivation not attributable to emotional distress, intellectual impairment, or diminished level of consciousness.”²¹¹ If adopted, an apathetic, unmotivated employee would arguably qualify for ADA protection. An employee who has no motivation to work on Fridays due to *DSM-5*-blessed Apathy Syndrome would qualify for entrance into the interactive ADA accommodation process with their employers if he or she can show an ability to perform the core functions of the job with a reasonable accommodation.

V. LIVING WITH THE *DSM-5*

Although the “recklessly expansive suggestions go on and on,”²¹² they reflect a fundamental change in the *DSM* that may require the legal community to remove the *Manual* from its current lofty perch of authority. The removal of the multiaxial system,²¹³ and proposed

207. Ivan Goldberg, Posting to PSYCOM.NET (Mar. 16, 1995 5:06 PM), <http://web.urz.uni-heidelberg.de/Netzdienste/anleitung/wwwtips/8/addict.html>. See also Anne Federwisch, *Internet Addiction*, NURSE.COM (Aug. 8, 1997), <http://www.nurseweek.com/features/97-8/iadct.html> (describing Dr. Goldberg's spoof).

208. See, e.g., John M. Grohol, *Pediatrics Gets It Wrong about 'Facebook Depression'*, PSYCHCENTRAL (Mar. 28, 2011), <http://psychcentral.com/blog/archives/2011/03/28/pediatrics-gets-it-wrong-about-facebook-depression/> (detailing lack of medical evidence to support the report in *Pediatrics*).

209. See *Conditions Proposed by Outside Sources*, *supra* note 153. At least one federal court has spoken on the issue of Internet sex addictions and denied ADA protection because of the Act's sexual disorder exceptions. *Pacenza v. IBM Corp.*, 363 F. App'x 128, 131 (2d Cir. 2010) (affirming district court holding that sex addiction is not a disability under the ADA and that sex addiction symptoms do not put employer on notice of employee's PTSD), *aff'g* No. 04 Civ. 5831 (PGG), 2009 WL 890060 (S.D.N.Y. Apr. 2, 2009).

210. See *Conditions Proposed by Outside Sources*, *supra* note 153.

211. Robert S. Marin, *Apathy: A Neuropsychiatric Syndrome*, 3 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCE 243–46 (1991). The *DSM-5* website does not include definitions for these disorders, indicating that the work groups are “further assessing the evidence” before making a recommendation. See *Conditions Proposed by Outside Sources*, *supra* note 153.

212. See Frances, *It's Not Too Late*, *supra* note 128 (discussing some of the “most egregious invasions of normality suggested for *DSM-V*”).

213. See APA Approves *DSM-5*, *supra* note 5, at 2 (announcing that the “*DSM-5* will move to a nonaxial documentation of diagnosis”). For more information about the multiaxial system, see

changes like those described above, reflect the *DSM*'s continued move towards a spectrum model of mental illness.²¹⁴ This involves the "clustering of disorders into illness spectra (e.g., psychotic, bipolar, cognitive) and extension farther into the softer ends of these spectra,"²¹⁵ meaning that the *DSM* will increasingly attempt to capture "the sub-threshold (e.g., minor depression, mild cognitive disorder) or premorbid (e.g., prepsychotic) versions of the existing official disorders."²¹⁶ I agree with both medical and nonmedical critics who contend that the *DSM-5* will create millions of new diagnosed "illnesses," whether or not they exist medically (or legally). Dr. Frances writes that it will be "a bonanza for the pharmaceutical industry but at a huge cost to the new false-positive patients caught in the excessively wide [*DSM-5*] net."²¹⁷ Importantly, though, the cost also extends to the legal community.

The threshold coverage issue of "disability" has been defined into virtual irrelevance under the ADAAA,²¹⁸ the EEOC's regulations,²¹⁹ and recent case law.²²⁰ As individuals learn more about the new *DSM-5* mental disorders and the ADAAA's relaxed definition of "disability," more individuals will request accommodation. While the wider *DSM-5* net will undoubtedly catch individuals unfairly excluded from the interactive process under the *DSM-IV* and pre-ADAAA regimes, it will also attract others who want to game the system. The regulatory impact analysis that accompanied the proposed regulations recited that as many as one million additional individuals may consistently meet the

text accompanying notes 26 and 40.

214. Frances, *It's Not Too Late*, *supra* note 128. See also Joseph M. Pierre, *The Borders of Mental Disorder in Psychiatry and the DSM: Past, Present, and Future*, 16 J. PSYCHIATRIC PRAC. 375, 378–79 (2010) (discussing the *DSM*'s spectral model in the context of personality disorders).

215. Pierre, *supra* note 214, at 379.

216. Allen Frances, *A Warning Sign on the Road to DSM-V: Beware of its Unintended Consequences*, PSYCHIATRIC TIMES (June 26, 2009), <http://www.psychiatrictimes.com/print/article/10168/1425378?printable=true>.

217. *Id.*

218. See ADAAA, § 2 (codified at 42 U.S.C. § 12101 (2006)) (reciting findings and purposes).

219. See, e.g., 29 C.F.R. § 1630.2(j)(1)(ii) (2012) (explaining that under the ADAAA, an impairment is a disability within the meaning of the statute where "it substantially limits the ability of an individual to perform a major life activity as compared to most people in the general population. An impairment need not prevent, or significantly or severely restrict, the individual from performing a major life activity in order to be considered substantially limiting"); *id.* § 1630.2(j)(1)(vii) ("An impairment that is episodic or in remission is a disability if it would substantially limit a major life activity when active.").

220. See *Villanti v. Cold Spring Harbor Cent. Sch. Dist.*, 733 F. Supp. 2d 371, 377 (E.D.N.Y. 2010) ("The ADAAA substantially broadened the definition of a 'disability' under the law, and explicitly overturned the Supreme Court's holdings in [*Sutton*] and [*Toyota*], which had defined the statutory terms 'substantially limits' and 'major life activities' strictly.").

ADAAA's definition of "disability," costing employers as much as \$235 million per year over five years for additional accommodations.²²¹ With the relaxation of the *DSM-5*'s standards, one million presumably unfairly excluded individuals may pale in comparison to the total number of newly "disabled" individuals under the *DSM-5*.

Although the ADAAA, combined with the release of the *DSM-5*, may create significant uncertainty, the legal community can take steps to limit this dangerous interaction. Regardless of the relative wisdom of the *DSM-5* approach for the medical community, the "spectralization" of mental illness²²² means that legal practitioners, including courts and government agencies, must take seriously the admonitions in the *DSM-IV*²²³ (which will presumably carry over to the *DSM-5*) and remove the *DSM* from its lofty pedestal of authority. Even though the ADAAA has drastically lowered the bar for determining a disability and when that disability substantially limits a major life activity, courts must retain the healthy skepticism of medical evidence that they employed in the pre-ADAAA landscape.²²⁴

Even under the ADAAA, medical diagnoses should not automatically qualify an individual for a legal "diagnosis" of disability. It is simply not the case that most individuals diagnosed with impairments on the spectrum of mental disorders are disabled as a matter of law. The *DSM-IV* itself admonishes that 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-IV mental disorder is not sufficient to establish the existence for legal purposes of a 'mental disorder,' 'mental disability,' 'mental disease,' or 'mental defect.'"²²⁵ Instead, the *DSM-IV* reminds the legal community that, "[w]hen used appropriately, diagnoses and diagnostic information can *assist* decision makers in their determinations."²²⁶

As one court noted, "additional information . . . beyond that

221. See Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, as amended, 74 Fed. Reg. 48431, 48437 (Sept. 23, 2009) (codified at 29 C.F.R. pt. 1630 (2012)) (listing the proposed regulations to the ADAAA).

222. See Pierre, *supra* note 214, at 377–79 (discussing the diagnostic spectra for mental disorders).

223. See *supra* notes 33–40, 71 and accompanying text.

224. See, e.g., Rolland v. Potter, 492 F.3d 45, 49 (1st Cir. 2007) (discounting medical evidence in light of plaintiff's ability to perform work); Squibb v. Memorial Med. Ctr., 497 F.3d 775, 784–85 (7th Cir. 2007) (declining to infer certain limitations from medical evidence); Dattoli v. Principi, 332 F.3d 505, 506–07 (8th Cir. 2003) (discounting medical evidence in light of plaintiff's ability to perform daily tasks); Taylor v. Pathmark Stores, Inc., 177 F.3d 180, 186–87 (3rd Cir. 1999) (same); Talk v. Delta Airlines, Inc., 165 F.3d 1021, 1025 (5th Cir. 1999) (same).

225. *DSM-IV*, *supra* note 1, at xxiii

226. *Id.* at xxxiii.

contained in the DSM[] diagnosis” is needed to determine whether an individual’s impairment meets any particular legal standard.²²⁷ Although the statement was removed from the EEOC’s final regulations, courts should be reminded of the proposed regulations’ statement that disability determinations “often may be made using a common-sense standard, without resorting to scientific or medical evidence.”²²⁸ For example, in 1998, the Sixth Circuit noted in dicta that the “inability to drive in darkness is a common phenomenon that, if classified as disabling, would make most of the American population over the age of 45 ‘disabled’ under the Act.”²²⁹ As the *DSM* moves further and further away from ADA jurisprudence, courts must reassess their deference to it and return the *DSM* to its proper place as one more piece of evidence that assists, but not directs, the outcome of a matter.

At the same time, employers and employees cannot rely solely on the court system to address these burdens. In states like Connecticut that explicitly adopt the latest edition of the *DSM* as the foundation of employment discrimination law,²³⁰ employers and employees cannot avoid the consequences of the APA’s decisions. Outside the courts, the “spectralized” *DSM-5*, combined with the lower standards in the ADAAA, will increase non-litigation costs for employers and employees because of the increased attention to the interactive process and the increase in employees requesting accommodation. Employers must assume that most individuals requesting accommodation would be found “disabled” under the ADAAA or at least would raise enough fact-intensive issues to lead to more extensive (and expensive) discovery, and even to trial. As much as some employers may want to chuckle at the absurdity of an older employee seeking accommodation for Mild Neurocognitive Disorder, they still must pay more attention to the interactive process in order to minimize exposure for failure to accommodate claims and the uncertainty of litigation.²³¹

227. *Bercovitch v. Baldwin Sch., Inc.*, 133 F.3d 141, 155 n.18 (1st Cir. 1998).

228. Regulations to Implement the Equal Employment Provisions of the Americans with Disabilities Act, as amended, 74 Fed. Reg. 48431, 48440 (Sept. 23, 2009) (codified at 29 C.F.R. pt. 1630 (2012)).

229. *Wade v. Gen. Motors Corp.*, 165 F.3d 29 (table), 1998 WL 639162, at *2 (6th Cir. Sept. 10, 1998).

230. See *supra* note 146 (noting that the Connecticut employment discrimination statutes explicitly refer to the APA’s ‘Diagnostic and Statistical Manual of Mental Disorders’).

231. Of course, even if employers have no *legal* obligation to accommodate certain employees, employers should still consider affording reasonable accommodations of some sort. Providing a reasonable, appropriate accommodation, whether legally mandated or not, is often simpler and more cost-effective than determining whether a legal duty exists and how to calibrate the appropriate accommodation to both the disability and the law.

CONCLUSION

Regardless of what the APA's Board of Trustees finally approves in the *DSM-5*, as a legal matter, prudent employers should assume that all but the most transitory and minor of impairments (the common cold or flu, a sprained ankle, or a pulled hamstring) will be found to be "disabilities." To fulfill their legal obligations under the ADA, employers should respond to all requests for accommodation, even if the diagnosed "impairment" seems ludicrous on its face. Careful preparation for and engagement in the interactive ADA accommodation process will minimize exposure for failure to accommodate claims and focus both parties on the issues most relevant to post-ADAAA litigation (i.e., whether the employee is "qualified" and what motivations the employer has for its actions).

This Article casts a critical eye on the proposed *DSM-5*. The additions and general reduction in diagnostic criteria for common disabilities cited in ADA and FMLA cases, such as Major Depressive Disorder and Generalized Anxiety Disorder, should bear close scrutiny both as the May 2013 publication deadline approaches and as medical and legal practitioners begin relying on the *DSM-5* in the coming years.