

COULD THE AMERICAN PSYCHIATRIC ASSOCIATION CAUSE YOU HEADACHES? THE DANGEROUS
INTERACTION BETWEEN THE DSM-5 AND EMPLOYMENT LAW

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Introduction

Since its first publication in 1952, the American Psychiatric Association's Diagnostic and Statistical Manual (DSM)¹ has long served as the primary reference for mental health disorders not only for medical practitioners, but also for government agencies like the Social Security Administration and Veterans Administration, and both state and federal courts. The APA's fourth edition of its manual, commonly referred to as the DSM-IV, was first published in 1994, with only relatively minor "text revisions" in 2000. In May 2013, for the first time in nearly 20 years, the American Psychiatric Association plans to publish an entirely new edition.² As proposed, the DSM-5 (the Association plans to scrap the use of Roman numerals)³ would significantly expand a number of existing psychological disorders and add several new ones. The DSM-IV, like the editions before it, has long served as a primary authority for the legal community. The new Manual is still a work in progress, published only as proposed diagnostic criteria and assessment instruments on the DSM-5 website. However, the significant proposed revisions to a wide range of mental impairments mean that the legal community's relationship

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¹ Am. Psychiatric Ass'n, *Diagnostic & Statistical Manual of Mental Disorders* (4th ed. text rev. 2000). The DSM-IV is the current edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. See *infra* notes 25-52 and accompanying text. Although the current version is technically the 2000 text revision (the DSM-IV-TR), rather than the 1994 version (the DSM-IV), legal and agency practitioners rarely differentiate between the two. Accordingly, unless otherwise stated, this paper will rely on the 2000 text revision, and refer to it only as the DSM-IV.

² 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 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>.

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 (claims of “disability,” requests for reasonable accommodations), Family Medical Leave Act (definitions of a “serious illness”), the Age Discrimination in Employment Act, and even state statutes and workers compensation laws (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 paper 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 could impact whether employees can bring claims under the ADA, ADEA, FMLA, and various state statutes.

This paper 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. First, the paper will discuss the history and background of the DSM and its development into a de-facto legal treatise. In Part II, the paper highlights the strengths and weaknesses of the DSM-IV as a legal text. Next, the article explains the dangerous interaction between the ADA Amendments Act and the proposed DSM-5. In Part IV, the article will highlight 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, and the ADA in particular. Finally, to reduce the possible

unintended consequences of overly-expansive definitions, Part V will summarize specific approaches that courts, employers, employees, and legal practitioners should rely on to reduce the potential confusion and burdens caused by the impending 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 in other related areas, use the Diagnostic and Statistical Manual of Mental Disorders, and have elevated it to the level of a de facto legal treatise.⁴ This Manual contains uniform psychiatric standards developed by the American Psychiatric Association that define and classify mental and emotional disorders. The DSM also establishes detailed criteria that medical professional use to uniformly identify mental conditions, evaluate symptoms, establish diagnoses, and decide on appropriate treatment.⁵

A. Early Development

Prior to the 1920s, the psychiatric field often applied diagnostic categories for mental disorders inconsistently.⁶ 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.⁷ In 1928, the New York Academy of Medicine held a National Conference on the Nomenclature of Diseases in order to address the concerns of this movement.⁸ In 1932, the Conference published the first edition of A Standard

⁴ See *infra* notes 53-60 and accompanying text.

⁵ DSM-IV, *supra* note 1.

⁶ Anthony L. LaBruzza & José M. Méndez-Villarrubia, USING DSM-IV: A CLINICIAN'S GUIDE TO PSYCHIATRIC DIAGNOSIS 13 (2d ed. 1997).

⁷ *Id.*

⁸ *Id.*

Classified Nomenclature of Disease (SCND) was published in 1932.⁹ The SCND's first edition focused on standardizing and labeling severe neurological and psychiatric disorders that practitioners had identified in mental patients.¹⁰

With the SCND, mental health practitioners for the first time could 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.¹¹ More than ninety percent of the symptoms that military psychiatrists observed in veterans fell outside the diagnostic categories in the SCND.¹² To account for this broader range of disorders in World War II veterans, the United States Army and Navy embarked on their own expansion of the SCND standards.¹³ This effort culminated in the Veterans Administration's creation of a separate comprehensive psychiatric standard in 1946.¹⁴ Relying heavily on the Veterans Administration's standard, the sixth edition of the International Classification of Diseases (ICD), published in 1948, for the first time included a section on mental disorders.¹⁵

Once again, the psychiatric community faced divergent standards and terminology, including the SCND, the Veterans Administration's standard, and the ICD. In response, the American Psychiatric Association established the Committee on Nomenclature and Statistics to

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.* at 14.

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.* Originally known as the International Classification of Causes of Death, the ICD's sixth edition effectively supplanted the SCND. World Health Org. *History of the development of the ICD*, <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) and *infra* notes 17-29 and accompanying text.

review the differing standards.¹⁶ In 1952, the Committee's published its findings and conclusions as the first edition of the Diagnostic and Statistical Manual, or DSM-I.¹⁷

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

However, the Association's release of DSM-I 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).¹⁸ To address these concerns, the American Psychiatric Association and the World Health Organization's Eighth Revision Conference published the DSM-II and ICD-8 in 1968 as a collaborative effort at harmonizing the competing classification systems.¹⁹ The DSM-II used a hierarchy of classifications starting with organic mental disorders and followed by psychotic, neurotic, and personality disorders, with each classification a subordinate of the one above it.²⁰ The hierarchical classifications proved both ambiguous—the differences between neurotic and psychotic disorders were poorly defined—and overly restrictive, since 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.²¹

With the impending release of ICD-9, the American Psychiatric Association revised the DSM again 1980.²² The DSM-III eliminated the hierarchical classifications found in DSM-II and created new diagnostic categories centered on psychopathology, including Mood, Anxiety,

¹⁶ LaBruzza & Méndez-Villarrubia, *supra* note 6, at 14.

¹⁷ American Psychiatric Ass'n, DIAGNOSTIC & STATISTICAL MANUAL OF MENTAL DISORDERS (1st ed. 1952).

¹⁸ LaBruzza & Méndez-Villarrubia, *supra* note 6, at 14; ICD-10 Vol. 2, *available at* www.who.int/classifications.

¹⁹ Reid & Wise, *supra* note 15, at 4; *see also* American Psychiatric Ass'n, Diagnostic & Statistical Manual of Mental Disorders (2d ed. 1968).

²⁰ American Psychiatric Ass'n, DSM-IV Options Book: Work in Progress 1 (1991).

²¹ *Id.*

²² Reid & Wise, *supra* note 15, at 4; American Psychiatric Ass'n, Diagnostic & Statistical Manual of Mental Disorders [hereinafter DSM-III] (3d ed. 1980).

Somatoform, and Dissociative Disorders, in a multi-axial system.²³ Additionally, the DSM-III for the first time allowed for the possibility of multiple diagnoses, further distancing itself from the hierarchies defined in the DSM-I and DSM-II.²⁴

To coincide with the release of the ICD-10, the American Psychiatric Association again revised the DSM in 1994.²⁵ The DSM-IV, the most comprehensive diagnostic manual to date, made numerous changes and additions to the revised DSM-III.²⁶ For example, the DSM-IV provided for psychosocial and environmental problems that influence the diagnosis, treatment, and prognosis of mental disorders.²⁷ These factors included major (often negative) life events, familial or other interpersonal stressors, and a lack of social support or personal resources.²⁸ 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.²⁹

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 American Psychiatric Association began developing the DSM-5, the DSM-IV faced its own wave of criticism from scholars, and particularly the development of the diagnostic categories.³⁰ Critics also complained of political pressure on the American

²³ DSM-III, *supra* note 22.

²⁴ *Id.*

²⁵ Reid & Wise, *supra* note 15, at 5.

²⁶ The Association had made minor revisions to the DSM-III in 1987. American Psychiatric Ass’n, *Diagnostic & Statistical Manual of Mental Disorders* (3d ed. rev. 1987).

²⁷ DSM-IV, *supra* note 1, at 28 (Axis IV).

²⁸ 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).

²⁹ John M. Oldham, *Personality Disorders*, in 3 *FOCUS* 372-82 (2005).

³⁰ 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).

Psychiatric Association’s process for creating the DSM-IV.³¹ However, and notwithstanding the deference that the legal community often gives the DSM,³² the DSM-IV is simply a consensus-built medical text with the attendant limits.³³ It is not a psychiatric “bible.”³⁴ The American Psychiatric Association 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.³⁵ The committees develop and revise diagnoses in each subsequent edition of the Manual based on research and clinical experience.³⁶

Accordingly, the DSM is useful when classifying patient 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 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 allows practitioners to more easily evaluate patients with multiple conditions and stressors beyond a primary diagnosis, using the Global Assessment of Functioning or GAF score.³⁷

For legal practitioners, the DSM-IV helpfully defines a mental disorder as “a clinically significant behavioral or psychological syndrome . . . that is associated with present distress or . .

³¹ 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).

³² See *infra* notes 53-60 and accompanying text.

³³ DSM-IV, *supra* note 1, at xxxiii.

³⁴ Andrew E. Taslitz, *Mental Health and Criminal Justice: An Overview*, 22 CRIM. JUST. 4, 5 (2007).

³⁵ DSM-IV, *supra* note 1, at xxxiii.

³⁶ *Id.* at xxxi.

³⁷ See, e.g., *Jelinek v. Astrue*, 662 F.3d 805, 807 & n.1 (7th Cir. 2011) (citing DSM-IV definition of a GAF score, a “psychiatric measure of a patient’s overall level of functioning”).

. disability.”³⁸ Importantly, this criterion required symptoms to cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning”³⁹ The DSM-IV also attempts to define what is *not* a mental disorder: “an expectable and culturally sanctioned response to a particular event.”⁴⁰ The DSM-IV also excludes deviant behavior or conflicts with society from the mental disorder classification, unless the deviance and conflicts are symptoms of another mental disorder identified in the Manual. As discussed in Part IV, the DSM-V proposes to relax these important foundational definitions in many areas.⁴¹

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

However, the DSM-IV is not without its weaknesses. The DSM-IV classifies a multitude of conditions as mental illnesses that can create confusion in legal contexts.⁴² 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 42 years earlier.⁴³

³⁸ DSM-IV, *supra* note 1, at xxxi. *But see id.*, at xxx (“[I]t must be admitted that no definition adequately specifies precise boundaries for the concept of ‘mental disorder.’”).

³⁹ Robert L. Spitzer & Jerome C. Wakefield, *DSM-IV Diagnostic Criterion for Clinical Significance: Does It Help Solve the False Positives Problem?*, in 156 *Am. J. of Psychiatry* 1856-64 (1999).

⁴⁰ *Id.*

⁴¹ *See infra* notes 116-206 and accompanying text.

⁴² 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.* at 586-87. 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 this author is 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.

⁴³ *Compare* DSM-IV, *supra* note 1, at 13-26 (listing all recognized disorders) *with* DSM-I, *supra* note 17.

Unfortunately, the rapid expansion of listed mental illnesses was not the result of improvements in their diagnosis.⁴⁴ 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.”⁴⁵ Other new diagnoses in the DSM-IV included personality disorders, which are pervasive and rigid patterns of maladaptive behavior.⁴⁶ 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”⁴⁷ Accordingly, psychiatrists must rely on subjective cultural standards to diagnose these types of disorders.

Among several cautionary statements that implicitly recognize the Manual’s limitations, the DSM-IV warns that the “assignment of a particular diagnosis does not imply a specific level of impairment or disability.”⁴⁸ Therefore, an individual may be depressed, and even meet the DSM-IV’s diagnostic criteria for major depression, 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 depression, and various psychoses, but still be found competent to stand trial. 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.

⁴⁴ 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).

⁴⁵ *Id.* at 114.

⁴⁶ DSM-IV, *supra* note 1, at 685.

⁴⁷ *Id.* at 686.

⁴⁸ *Id.* at xxxiii.

The lack of clarity in the DSM-IV about how to define a mental illness,⁴⁹ 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.⁵⁰ Even Congress has rejected a statutory definition that would explicitly require group health plans to adopt all DSM diagnoses.⁵¹

C. Use of the DSM in Legal Contexts

Despite these weaknesses and the admonitions in the DSM itself 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,”⁵² the DSM-IV has found wide application far beyond doctors’ offices and medical journals. Courts, legislators, and agencies have relied on the DSM-IV as an important and persuasive text in a range of cases implicating mental illness from employment discrimination⁵³ to criminal law⁵⁴ to Social Security disability,⁵⁵ and even health plan

⁴⁹ *Id.* at xxx (“[I]t must be admitted that no definition adequately specifies precise boundaries for the concept of ‘mental disorder.’”).

⁵⁰ *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).

⁵¹ As part of Public Law 110-343, 122 Stat. 3765 (2008)—a law best known for creating the Troubled Asset Relief Program or 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 (2010), 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.

⁵² DSM-IV, *supra* note 1, at xxxii-xxxiii.

⁵³ *E.g.*, *Scheerer v. Potter*, 443 F.3d 916, 920 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) (holding that “major depressive episode as described in the [DSM-IV] constitutes ‘mental impairment’” under the Rehabilitation Act), *aff’d*, 965 F.2d 794 (2d Cir. 1992).

administration.⁵⁶ Courts have referred to the DSM-IV as a “nationally recognized directory of mental illness,”⁵⁷ a “reliable text,”⁵⁸ “specialized literature” with a rigorous process for including mental illnesses.⁵⁹ Courts have also held that government agencies can reasonably rely on the DSM-IV to determine eligibility for their health plan’s disability benefits.⁶⁰

Battles over the DSM and its proper meaning have even reached Supreme Court decisions. For example, in *Atkins v. Virginia*,⁶¹ the Court considered the constitutionality of imposing the death penalty on defendants who are intellectually disabled/mentally retarded. Writing for the majority, Justice Stevens’s referred to the DSM-IV,⁶² and the joint amicus curiae brief filed by the American Psychological Association and the American Psychiatric Association.⁶³ 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.”⁶⁴ In dissent, Justice Scalia, focused on this definition and remarked that “the symptoms of this condition can readily be feigned.”⁶⁵

Thus, even at the highest levels, legal practitioners often rely heavily on the DSM-IV when making legal determinations (in *Atkins*, whether intellectual disability/mental retardation can be diagnosed in a defendant and in Congress in determining what group health plans must

⁵⁴ *E.g.*, *Clark v. Arizona*, 548 U.S. 735, 774 (2006) (citing DSM-IV’s diagnostic definition of schizophrenia in case regarding state insanity defense standards).

⁵⁵ *E.g.*, *Jelinek v. Astrue*, 662 F.3d 805, 807 & n.1 (7th Cir. 2011) (citing 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).

⁵⁶ *Fuller v. J.P. Morgan Chase*, 423 F.3d 104, 105-06 (2d Cir. 2005) (citing disability plan’s reliance on DSM-IV definitions when making disability coverage determinations).

⁵⁷ *Pandazides v. Virginia Bd. of Educ.*, 804 F. Supp. 794, 803 (E.D. Va. 1992) (describing DSM-IV as a “nationally recognized directory of mental illness”), *rev’d on other grounds*, 13 F.3d 823 (4th Cir. 1994).

⁵⁸ *United States v. Danser*, 110 F. Supp. 2d 807, 829 (S.D. Ind. 1999).

⁵⁹ *Discepolo v. Gorgone*, 399 F. Supp. 2d 123, 127 (D. Conn. 2005).

⁶⁰ *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.”)

⁶¹ 536 U.S. 304 (2002).

⁶² *Id.* at 308 n.3.

⁶³ *Id.* at 316 n.21

⁶⁴ *Id.* at 318.

⁶⁵ *Id.* at 353 (Scalia, J., dissenting).

cover). However, this overreliance 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 lists of disorders.⁶⁶ 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.⁶⁷

The DSM-IV itself cautions the legal community from attaching too much importance to the Manual when making conclusions of law such as those described above, and explains why heavy reliance is dangerous. The Manual offers that

These dangers arise because of the imperfect fit between the questions of ultimate concern to the law and the information contained in a clinical diagnosis. 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 disease,” or “mental defect.” In determining whether an individual meets a specified legal standard (e.g., for competence, criminal responsibility, or disability), additional information is usually required beyond that contained in the DSM-IV diagnosis.⁶⁸

The danger of overreliance on the DSM comes into clearer focus with the impending release of the new DSM-5. To understand why, Part III of this paper presents a brief primer on the changes to the ADA implemented by the ADA Amendments Act of 2008 (the “ADAAA”),⁶⁹ with a focus on mental impairments in particular, before Part IV describes the dangerous potential interaction between the ADAAA and the DSM-5.

⁶⁶ S. Nassir Ghaemi, THE CONCEPTS OF PSYCHIATRY 172 (2003).

⁶⁷ *E.g.*, *id.* at 53; Philip Thomas et al., *Explanatory Models for Mental Illness: Limitations and Dangers in a Global Context*, 2 PAK. J. NEUROLOGICAL SCI. 176, 177 (2007); John Sorboro, *The Trouble with Psychiatry*, SKEPTIC MAG., Sept. 22, 2007, at 37, 38-39.

⁶⁸ DSM-IV, *supra* note 1, at xxxiii.

⁶⁹ *See generally* ADA Amendments Act of 2008, Pub. L. No. 110-325, § 8 (codified at 42 U.S.C. §§ 12101 *et seq.*) (hereinafter “ADAAA”).

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, and it took effect the following January 1st.⁷⁰ 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. Primarily, the ADAAA addressed the controversies created by two Supreme Court cases interpreting the ADA: *Sutton v. United Air Lines*⁷¹ from 1999 and *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams*⁷² from 2002.

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.⁷³ The Supreme Court held that any measures that an individual took to mitigate a physical or mental impairment must be taken into account in determining whether an individual is "disabled."⁷⁴ Subsequent district and appellate court decisions relied on *Sutton* to find that some mental impairments would not constitute "disabilities" where they were adequately controlled by medication.⁷⁵

Toyota considered whether an employer had failed to accommodate a claim by a plaintiff with carpal tunnel syndrome. The Court held that an impairment must "prevent" or "severely

⁷⁰ *Id.*

⁷¹ 527 U.S. 471 (1999).

⁷² 534 U.S. 184 (2002).

⁷³ *Sutton*, 527 U.S. at 482.

⁷⁴ *Id.*

⁷⁵ *E.g.*, *Collins v. Prudential Inv. and Ret. Servs.*, 119 F. App'x 371, 378 (3d Cir. 2005) (ADD/ADHD not a "disability" where it is corrected through medication).

restrict” a major life activity to constitute a “substantial limitation” on that activity.⁷⁶ Further held that a “major life activity” must be an activity “of central importance to daily life.”⁷⁷ Prior to the EEOC’s publication of post-ADAAA regulations in March 2011,⁷⁸ ADA regulations had defined terms like “substantially limits” in similarly restrictive terms to mean “unable to perform” a major life activity, or “significantly restricted” in the performance of that activity.⁷⁹

The ADAAA also allowed Congress to resolve additional controversies raised by Supreme Court dicta, lower court decisions, and circuit splits among the appellate courts. Pre-ADAAA courts had split over the issue of whether individuals covered under the ADA’s “regarded as” disabled prong were entitled to reasonable accommodations.⁸⁰ Appellate courts had also split over whether plaintiffs who claimed they were “regarded as” disabled also had to prove that defendants had perceived those real or imagined disabilities as “substantially limiting” as well.⁸¹

Pre-ADAAA Supreme Court law also required a mental (or physical) impairment to have a “permanent or long term” impact.⁸² Accordingly, many district and circuit courts declined to find an impairment substantially limited a plaintiff if the impairment was merely episodic or in

⁷⁶ *Toyota*, 534 U.S. 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). *Hold v. Grand Lake Mental Ctr., Inc.*, 443 F.3d 762, 766-67 (10th Cir. 2006) (plaintiff with cerebral palsy not “disabled” where she was not restricted in the ability to perform a “broad range of manual tasks”);

⁷⁷ *Toyota*, 534 U.S. at 185.

⁷⁸ 76 Fed. Reg. 16978 *et seq.* (Mar. 25, 2011).

⁷⁹ See 29 C.F.R. § 1630.2(j)(1)(i)-(ii) (2002).

⁸⁰ See, e.g., *D’Angelo v. ConAgra Foods, Inc.*, 422 F.3d 1220, 1235 (11th Cir. 2005) (discussing circuit split).

⁸¹ See, e.g., *Sutton v. United Air Lines*, 527 U.S. 471, 490-91 (1999).

⁸² *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184, 185 (2002).

remission.⁸³ Some courts went further and found that episodic or intermittent mental disorders did not even constitute a “disability” under the ADA.⁸⁴

Pre-ADAAA courts often questioned whether “working” could qualify as a major life activity.⁸⁵ Although the regulations permitted plaintiffs to use “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.”⁸⁶

B. Changes to the Legal Landscape in the ADAAA

1. “Disability”

The ADAAA rejected the Supreme Court’s *Sutton* holding that the ADA required assessing a “disability” in light of measures that mitigated mental (or physical) impairments.⁸⁷ Instead, the Act required that assessment to be made without regard to the effects of mitigating measures.⁸⁸ The ADAAA further clarified that an impairment need not substantially limit more than one major life activity to constitute a “disability.”⁸⁹ 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.⁹⁰ Helpfully, Congress listed several examples of mitigating measures that must not be considered in determining whether a mental

⁸³ See, e.g., *E.E.O.C. 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.”).

⁸⁴ See, e.g., *Rohan v. Networks Presentations LLC*, 375 F.3d 266, 276 (4th Cir. 2004) (plaintiff with depression, PTSD not substantially limited in interacting with others where PTSD flashback episodes were “sporadic and last[ed], at most, thirty minutes”).

⁸⁵ See, e.g., *Toyota*, 523 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.

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

⁸⁷ See generally ADAAA, § 8 (codified at 42 U.S.C. §§ 12101 *et seq.*).

⁸⁸ *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)).

⁸⁹ See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(C)).

⁹⁰ See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(D)).

impairment constituted a “disability,” including “medication,” and “learned behavioral or adaptive neurological modifications.”⁹¹

2. “Substantially Limits”

The ADAAA rejected the Supreme Court’s *Toyota* holding that the ADA required an impairment to “prevent” or “severely restrict” a major life activity to constitute a “substantial limitation” on that activity.⁹² The Act also rejected the regulations’ restrictive definition of “substantially limits” as meaning “significantly restricted” in the performance of a major life activity.⁹³ 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.⁹⁴ 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,”⁹⁵ and reflected Congress’s expectation that the EEOC would revise its regulation defining the term “substantially limits.”⁹⁶

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.”⁹⁷ Instead, the Act provided two non-exclusive lists of “major life activities,”⁹⁸ one that contained traditional activities that the EEOC’s regulations previously recognized (plus a few activities only identified in court decisions and

⁹¹ See *id.* § 4(a) (codified at 42 U.S.C. § 12102(4)(E)(ii)).

⁹² See *id.* § 2(b)(4).

⁹³ See *id.* § 2(b)(6).

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

⁹⁵ See *id.* § 2(b)(5).

⁹⁶ See *id.* § 2(b)(6).

⁹⁷ See *id.* § 2(b)(4).

⁹⁸ See *id.* § 4(a) (codified at 42 U.S.C. § 12102(2)(A)-(B))

EEOC guidance),⁹⁹ 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.”¹⁰⁰ Helpfully for individuals with mental impairments, Congress included multiple potentially relevant “major life activities” and “major bodily functions” including sleeping, concentrating, thinking, communicating, and neurological and brain functions.¹⁰¹

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 limiting.”¹⁰² Instead, to satisfy this prong, the Act only required that plaintiffs 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.”¹⁰³ The ADAAA also provided that employers need not extent a reasonable accommodation to individuals who merely satisfy the “regarded as” definition of disability.¹⁰⁴

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

⁹⁹ Compare 29 C.F.R. § 1630.2(i) (2002), with ADAAA § 4(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. See *id.* § 4(a) (codified at 42 U.S.C. § 12102(2)(A)).

¹⁰⁰ See ADAAA § 4(a) (codified at 42 U.S.C. § 12102(2)(B)).

¹⁰¹ See *id.* § 4(a) (codified at 42 U.S.C. § 12102(2)(A)-(B)).

¹⁰² See *id.* § 2(b)(3).

¹⁰³ See *id.* § 4(a) (codified at 42 U.S.C. § 12102(3)(A)).

¹⁰⁴ See *id.* § 6(a)(1) (codified at 42 U.S.C. § 12201(h)).

favor of coverage, and does not require “extensive analysis.”¹⁰⁵ 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.¹⁰⁶

Critical to new DSM-5 definitions of illnesses such as major depressive disorder, 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.¹⁰⁷ Even impairments with a brief duration can be “substantially limiting” under the revised regulations.¹⁰⁸ The regulations also provide a nonexclusive list of such potential impairments, including major depressive disorder, bipolar disorder, post-traumatic stress disorder,” where it will “easily be concluded” that impairments limit a major life activity.¹⁰⁹ The regulations explicitly expand the list of major life activities as well, including the addition of “interacting with others.”¹¹⁰ 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 be considered in determining disability.¹¹¹ For mental impairments, this excludes the consideration of the effects of medication, learned or adaptive behaviors, or psychotherapy.¹¹² 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

¹⁰⁵ 29 C.F.R. §§ 1630.1(4), 1630.2(k)(2).

¹⁰⁶ § 1630.2(j)(1)(ii).

¹⁰⁷ § 1630.2(j)(1)(vii).

¹⁰⁸ § 1630.2(j)(1)(ix).

¹⁰⁹ § 1630.2(j)(3)(iii).

¹¹⁰ § 1630.2(i)(1)(i).

¹¹¹ § 1630.2(j)(1)(vi).

¹¹² § 1630.2(j)(5)(i), (iv), (v).

activity.¹¹³ While an employer is not required to provide reasonable accommodations to individuals who are only “regarded as” disabled under the ADA,¹¹⁴ 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.¹¹⁵

IV. Broadening Definitions: The Proposed DSM-5

A. Medical Community Criticisms of the DSM-5

After the publication of the text revisions to the DSM-IV in 2000, the American Psychiatric Association began preparing for the development of the DSM-5.¹¹⁶ Just as the DSM-IV received criticism during its development,¹¹⁷ the American Psychiatric Association’s development of the DSM-5 was met with considerable opposition from various medical and non-medical groups almost from the outset of the project. Psychiatrist Paul Chodoff sarcastically suggested in the American Psychiatric Association’s *Psychiatric News* that the DSM-5 should adopt his proposed diagnosis of “the human condition.”¹¹⁸ 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.”¹¹⁹ His comments underscored the psychiatric community’s unease with the ever-expanding DSM.

¹¹³ § 1630.2(l)(1).

¹¹⁴ § 1630.9(e).

¹¹⁵ § 1630.2(l)(1).

¹¹⁶ See *supra* note 2.

¹¹⁷ See *supra* note 31.

¹¹⁸ Dr. Paul Chodoff, Letter to the Editor: Proposed Diagnosis, *PSYCHIATRIC NEWS* (Jan. 21, 2005), <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=108472>.

¹¹⁹ *Id.*

Even the confidentiality agreement that the Association required 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-5.¹²⁰ In 2009, Robert Spitzer and Allen Frances, the Task Force chairs for the DSM-III and DSM-IV, respectively, excoriated the American Psychiatric Association'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."¹²¹

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."¹²² 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."¹²³ 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."¹²⁴ Other commentators cautioned that "diagnosis informs treatment decisions," and that even "small changes in symptom criteria" could have "significant impacts" on treatment.¹²⁵ Shortly after the publication

¹²⁰ Robert L. Spitzer, *Commentary: 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>.

¹²¹ Letter from Allen Frances & Robert Spitzer to the American Psychiatric Association Board of Trustees (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>.

¹²² *Id.*

¹²³ *Id.*

¹²⁴ Allen Frances, *It's Not Too Late to Save 'Normal'*, L.A. TIMES, Mar. 1, 2010, available at <http://articles.latimes.com/2010/mar/01/opinion/la-oe-frances1-2010mar01>.

¹²⁵ 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>.

of Spitzer and Frances's letter, the American Psychiatric Association 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") due in October 2013.¹²⁶ The delay did little to change the direction of the DSM-5, or the wealth of medical community criticism. The delay and ongoing debate should have raised red flags for legal practitioners.¹²⁷

In June 2011, the British Psychological Society lodged a highly critical response to the proposed revisions,¹²⁸ one that a host of other prominent psychological organizations and psychologists later adopted in an open online petition.¹²⁹ The British Psychological 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."¹³⁰ 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."¹³¹ 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." The Society

¹²⁶ See *supra* note 2.

¹²⁷ Indeed, it was the DSM-5 Task Force's announcement of the delayed publication that first brought the disputes about the DSM-5 to the attention of the author and his 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.

¹²⁸ British Psychological Soc'y, *Response to the American Psychiatric Association: DSM-5 Development*, June 2011, available at http://apps.bps.org.uk/_publicationfiles/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, available at http://apps.bps.org.uk/_publicationfiles/consultation-responses/DSM-5%202012%20-%20BPS%20response.pdf

¹²⁹ See *Open Letter to the DSM-5*, Oct. 22, 2011, available at <http://www.ipetitions.com/petition/dsm5/>.

¹³⁰ British Psychological Soc'y, *supra* note 128, at 2.

¹³¹ *Id.* at 3.

recommended that an ideal classification system would not be based on “preordained diagnostic categories” but rather would “begin from the bottom up – starting with specific experiences, problems or ‘symptoms’ or ‘complaints’.”¹³²

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 in January 2010.¹³³ However, his Q&A session with the newspaper only served to raise more red flags for DSM-5 critics and legal practitioners.¹³⁴ Dr. Narrow explained that the American Psychiatric Association felt a new DSM was necessary because the DSM-IV “was completed nearly two decades ago” and was “no longer considered up-to-date.”¹³⁵ 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 was vetting draft proposals against scientific findings and field testing, and focusing the DSM-5 to address “concerns” that the DSM-IV was too “biologically focused,”¹³⁶ oddly the polar opposite of major criticisms from the medical field and major media.¹³⁷ Importantly, but unsurprisingly, for legal practitioners, Dr. Narrow’s responded with an entirely clinical focus, not

¹³² *Id.*

¹³³ *Q&A with Dr. William Narrow, research director for the DSM 5 Task Force*, PITTSBURGH POST-GAZETTE, Jan. 30, 2012, available at <http://www.post-gazette.com/stories/news/health/qa-with-dr-william-narrow-research-director-for-the-dsm-5-task-force-219825>.

¹³⁴ 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. 11, 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*, FRANZCEK RADELET FR ALERT (Mar. 1, 2012), http://www.franczek.com/frontcenter-American_Psychiatric_Association_Impact_DSM-5.html (Legal update to firm clients regarding DSM-5 release).

¹³⁵ *Id.*

¹³⁶ See *id.*

¹³⁷ See *supra* notes 118-132 and accompanying text.

a legal one.¹³⁸ Dr. Narrow’s response demonstrates that not only will the medical profession likely have to live with the DSM-5 for better or for worse, but that legal practitioners will also—and with far less input into its development than practicing doctors may have. Even 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.¹³⁹

An editorial by Til Wykes and Felicity Callard, from King’s College London, neatly summarized the problems with the proposed revisions for DSM-5 after the DSM-5 Task Force released them in early 2010:

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.¹⁴⁰

Several proposals in particular not only risk misuse and overdiagnosis in various populations, but create legal concerns as well. The DSM-5’s proposals, as well as other recommendations currently “under consideration” by the DSM-5 Task Force could directly impact whether employees can bring claims under the Americans with Disabilities Act (“ADA”) (claims of “disability,” requests for reasonable accommodations), Family Medical Leave Act

¹³⁸ See, e.g., Benedict Carey, *Revising Book on Disorders of the Mind*, N.Y. TIMES, Feb. 10, 2010, A1, available at <http://www.nytimes.com/2010/02/10/health/10psych.html>.

¹³⁹ E.g., Ruth Colker et al., Comments on Proposed DSM-5 Criteria for Specific Learning Disorder from a Legal and Medical/Scientific Perspective, <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 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.

¹⁴⁰ Til Wykes & Felicity Callard, *Editorial, Diagnosis, Diagnosis, Diagnosis: Towards DSM-5*, 19 J. MENTAL HEALTH 301, 302 (2010).

(definitions of a “serious illness”) and even the Age Discrimination in Employment Act and workers compensation laws (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 directly¹⁴¹ 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 DSM-5 Task Force has proposed adding are attenuated psychosis syndrome,¹⁴² mild neurocognitive disorder,¹⁴³ social communication disorder,¹⁴⁴ and callous and unemotional specifier for conduct disorder.¹⁴⁵ Other changes under consideration by the Task Force include significant modifications to existing disorders including major depressive disorder¹⁴⁶ and generalized anxiety disorder.¹⁴⁷ The Task Force is also considering the addition of other questionably supportable disorders that were suggested by outside sources, such as

¹⁴¹ 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).

¹⁴² Am. Psychiatric Ass’n, *Attenuated Psychosis Syndrome*, DSM-5 DEVELOPMENT [hereinafter DSM-5] (Apr. 27, 2012), <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=412>.

¹⁴³ DSM-5, *S 03 Mild Neurocognitive Disorder* (Apr. 2012), <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=420>.

¹⁴⁴ DSM-5, *A 04 Social Communication Disorder* (May 1, 2012), <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=489>.

¹⁴⁵ DSM-5, *Q 02.1 Callous and Unemotional Specifier for Conduct Disorder* (Apr. 2012), <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=424>.

¹⁴⁶ DSM-5, *D 01 Major Depressive Disorder, Single Episode* (Apr. 2, 2012), <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=44>; DSM-5, *D 02 Major Depressive Disorder, Recurrent*, Apr. 2, 2012, <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=45>.

¹⁴⁷ DSM-5, *E 05 Generalized Anxiety Disorder* (Apr. 30, 2012), <http://www.dsm5.org/proposedrevision/pages/proposedrevision.aspx?rid=167>.

“apathy syndrome,” “Internet addiction disorder,” and “seasonal affective disorder” as psychiatric disorders.¹⁴⁸

1. Attenuated Psychosis Syndrome

One of the most contentious new disorders proposed for 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.”¹⁴⁹ In his recent interview, Dr. Narrow indicated that the American Psychiatric Association had estimated that nearly 80% of potential “attenuated psychosis syndrome” patients go undiagnosed under the DSM-IV.¹⁵⁰ 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 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 Task Force’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.¹⁵¹ The

¹⁴⁸ DSM-5, *Conditions Proposed by Outside Sources*, <http://www.dsm5.org/proposedrevisions/pages/conditionsproposedbyoutsidesources.aspx> (last visited Sept. 27, 2012).

¹⁴⁹ *See supra* note 142.

¹⁵⁰ *See supra* note 133.

¹⁵¹ 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

Task Force has recommended these conditions “for further study,” noting that they “require further research” before consideration as formal disorders.”¹⁵²

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,¹⁵³ the 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.¹⁵⁴ According to the proposed revision, Mild Neurocognitive Decline 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.”¹⁵⁵ Notably, the only “evidence” required for this diagnosis is the self-reported “[c]oncerns of the individual” or “a knowledgeable informant.”¹⁵⁶

DSM-5 critics have rightly argued that this definition is unacceptably broad. Allen Frances, for one, listed Mild Neurocognitive Decline as one of the “19 worst suggestions” for the DSM-5.¹⁵⁷ He argues that adding Mild Neurocognitive Decline risks medicalizing predictable

raised by the possible identification of this disorder, see Allen Frances, *Psychosis Risk Syndrome: Just as Risky with a New Name*, PSYCHOLOGY TODAY (July 30, 2010), <http://www.psychologytoday.com/blog/dsm5-in-distress/201007/psychosis-risk-syndrome-just-risky-new-name>, and Johnathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. OF L. & POL’Y 181, 249-53 & nn.432-53 (2012).

¹⁵² E.g., DSM-5, *Attenuated Psychosis Syndrome (Proposed for Section III of the DSM-5)* (Apr. 27, 2012), <http://www.dsm5.org/proposedrevision/Pages/proposedrevision.aspx?rid=412>.

¹⁵³ See, DSM-5, *Neurocognitive Disorders*, <http://www.dsm5.org/ProposedRevision/Pages/NeurocognitiveDisorders.aspx> (last visited Sept. 27, 2012).

¹⁵⁴ See *supra* note 143.

¹⁵⁵ *Id.*

¹⁵⁶ *Id.*

¹⁵⁷ 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>.

cognitive declines of aging.¹⁵⁸ Nonspecific symptoms as a “modest cognitive decline from a previous level of performance” are “very common (perhaps almost ubiquitous) in people over fifty.”¹⁵⁹ This creates the potential for millions of individuals, who will never develop dementia, to receive a diagnosis (or misdiagnosis) of Mild Neurocognitive Decline.¹⁶⁰ Although diagnosis nominally requires an “objective” cognitive assessment, even the DSM-5’s Neurocognitive Disorders Work Group recognizes that truly objective clinical assessments may be problematic.¹⁶¹ 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 thirteen percent of the population.¹⁶²

The problems with misdiagnosis of Mild Neurocognitive Decline extend beyond the medical context and into the employment relationship. The Seventh Circuit in distinguishing ADA and ADEA claims has cautioned, “[o]ld age . . . does not define a discrete and insular minority because all persons, if they live out their normal life spans, will experience it.”¹⁶³ Older employees are protected from discrimination under the Age Discrimination in Employment Act (ADEA), 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.”¹⁶⁴ On the other hand, 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 accommodation for these cognitive

¹⁵⁸ *Id.*

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ See *supra* note 143 (“[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.”).

¹⁶² *Id.*

¹⁶³ *Erickson v. Bd. of Governors of State Colls. & Univs. for Ne. Ill. Univ.*, 207 F.3d 945, 950, (7th Cir. 2000) (quoting *Kimel v. Florida Bd. of Regents*, 528 U.S. 62, 83 (2000)).

¹⁶⁴ *Detz v. Greiner Industries, Inc.*, 346 F.3d 109, 117 (3rd Cir. 2003).

deficits using the DSM-5's Mild Neurocognitive Decline, thereby transforming their ADEA claims into ones under the ADA, and pursuing 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 includes the key phrase that “accommodation may be required.”¹⁶⁵ While commentators have rightly argued that the ADEA has failed to address the continued emergence of ageist stereotypes and associated discrimination,¹⁶⁶ 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.

3. Social Communication Disorder

Another puzzling proposed addition to the DSM-5 is “Social Communication Disorder.”¹⁶⁷ Categorized as a neurodevelopment disorder with language and speech disorders like ADHD, autism, Tourette’s,¹⁶⁸ the 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.”¹⁶⁹ Another one of the diagnostic criteria suggests that people with “[p]ersistent difficulties in . . . the social uses of verbal and nonverbal communication . . . which affects the development of social reciprocity and social relationships” meet the DSM-5 definition.¹⁷⁰ While

¹⁶⁵ See *supra* note 143.

¹⁶⁶ E.g., Judith J. Johnson, *Reasonable Factors Other Than Age: The Emerging Specter of Ageist Stereotypes*, 33 SEATTLE U. L. REV. 49 (2009).

¹⁶⁷ See *supra* note 144.

¹⁶⁸ See, DSM-5, *Neurodevelopmental Disorders*, <http://www.dsm5.org/ProposedRevision/Pages/NeurodevelopmentalDisorders.aspx> (last visited Sept. 27, 2012).

¹⁶⁹ See *supra* note 144.

¹⁷⁰ *Id.*

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 has defined it so broadly that it could also match just about any of the “geeks, sportos, motorheads, dweebs, dorks, sluts, buttheads”¹⁷¹ or other individuals in a workplace who might struggle to fit in due to their particular eccentricities. With the lowered ADAAA bar, potentially tens of thousands of employees and their employers could be forced into the ADA interactive process unnecessarily (or decline to do so at great expense).¹⁷² Despite the reference to a classic ‘80s film,¹⁷³ the concern about employees who do not “fit in” is not a trivial one in the workplace. The author’s management-side labor and employment law firm¹⁷⁴ 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

Finally, a fourth proposed addition to the DSM-5 is the obtusely named “Callous and Unemotional Specifier for Conduct Disorder.”¹⁷⁵ The DSM-5 lists this new disorder among disruptive, impulse control, and conduct disorders such as Oppositional Defiant Disorder and

¹⁷¹ 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.”)

¹⁷² See, e.g., Walter Olson, *Revised DSM-5 Could Open Up Wider Legal Claims*, CATO@LIBERTY (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).

¹⁷³ See *supra* note 171.

¹⁷⁴ Franczek Radelet, P.C., <http://www.franczek.com/> (last visited Sept. 27, 2012).

¹⁷⁵ See *supra* note 145.

Intermittent Explosive Disorder.¹⁷⁶ 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.”¹⁷⁷ As with Social Communication Disorder, Callous and Unemotional Specifier for Conduct Disorder medicalizes what others would have categorized as part of the human condition.¹⁷⁸ 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.

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 try to dismiss or ignore. The DSM-5 also proposes removing the implicit “bereavement exclusion” from the diagnostic definition of Major Depressive Disorder, which consists of one or more Major Depressive Episodes.¹⁷⁹ The DSM-IV’s definition of what constituted a Major Depressive Episode¹⁸⁰ specifically exempted bereavement or other events involving a significant loss, even when symptoms lasted the requisite two weeks.¹⁸¹ However, the DSM-5 reverses this definition, explicitly stating that “[t]he normal and expected response to an event involving significant loss (e.g., bereavement, financial ruin, natural disaster) may resemble a depressive

¹⁷⁶ See DSM-5, *Disruptive, Impulse Control, and Conduct Disorders*, <http://www.dsm5.org/ProposedRevision/Pages/Disruptive,ImpulseControl,andConductDisorders.aspx> (last visited Sept. 27, 2012).

¹⁷⁷ See *supra* note 145.

¹⁷⁸ See *supra* notes 118-119 and accompanying text.

¹⁷⁹ See *supra* note 146.

¹⁸⁰ See DSM-5, *Major Depressive Episode* (Apr. 30, 2012), <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=427>.

¹⁸¹ See *id.* (DSM-IV definition).

episode,” and when combined with symptoms of other functional impairments “suggest the presence of a Major Depressive Episode.”¹⁸²

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 diagnosed with Major Depressive Disorder.¹⁸³

This significant change would increase the diagnosis of Major Depressive Disorder and medicalize normal grief.¹⁸⁴ Allen Frances labeled this change another of the nineteen worst in the DSM-5.¹⁸⁵ From a legal standpoint, the DSM-5’s proposed transformation of grief, a normal life process, into a diagnosable mental illness means that employers’ “bereavement leave” policies may no longer suffice. Instead, employers and employees could again be dumped into the ADA interactive process, FMLA leave discussions, and other unnecessary legal discussions.

Another suggested change in the DSM-5 is to Generalized Anxiety Disorder.¹⁸⁶ While the general criteria—symptoms like restlessness, anxiety and worry, distress, and impairment of social functioning—remain largely unchanged, the DSM-5 proposes lowering the threshold of these symptoms for diagnosis.¹⁸⁷ First, the DSM-5 proposes reducing the required duration of these symptoms to just three months.¹⁸⁸ Second, the DSM-5 proposal reduces the number of

¹⁸² *Id.*

¹⁸³ *Id.*

¹⁸⁴ Frances, *supra* note 157.

¹⁸⁵ *Id.*

¹⁸⁶ *See supra* note 147.

¹⁸⁷ *See id.* (DSM-5 and DSM-IV definitions).

¹⁸⁸ 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*, PSYCHOLOGY TODAY (Apr. 12, 2011), <http://www.psychologytoday.com/blog/dsm5-in-distress/201104/dsm-5-will-medicalize-everyday-worries-generalized-anxiety-disorder>.

different associated behaviors required for diagnosis.¹⁸⁹ Under the DSM-IV, patients needed to exhibit three out of six behaviors: restlessness, fatigue, difficulty concentrating, irritability, muscle tension, or sleep disturbance.¹⁹⁰ The DSM-5 requires only that patients show either restlessness or muscle tension, and one of: avoidance of activities, excessive time and effort to prepare for activities, procrastination, or seeking reassurance from others due to worries.¹⁹¹ Critics have characterized the rationale for these “radical changes” as “completely unconvincing” and “remarkably thin.”¹⁹² The proposed criteria not only significantly lower the diagnostic threshold for this Generalized Anxiety Disorder, but the DSM-5 list of symptoms seems difficult to distinguish from the normal anxieties of everyday life.

6. Outside Proposals Under Consideration for the DSM-5.

The DSM-5 also proposes 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.¹⁹³ The DSM-IV logically excluded deviance and conflict from the definition, except to the extent they were symptoms of another, diagnosable dysfunction.¹⁹⁴

However, the DSM-5 suggests that a mental disorder *can* be the result of these factors so long as they are not “primarily” the cause.¹⁹⁵ Medical critics have observed that the lack of consensus as to the “primary” causes of mental distress could result in practitioners classifying

¹⁸⁹ See *supra* note 147.

¹⁹⁰ *Id.*

¹⁹¹ *Id.*

¹⁹² Francez, *supra* note 188.

¹⁹³ See DSM-5, *Definition of a Mental Disorder*, <http://www.dsm5.org/ProposedRevisions/Pages/proposedrevision.aspx?rid=465> (last visited Sept. 27, 2012).

¹⁹⁴ *Id.* (DSM-IV definition).

¹⁹⁵ *Id.* (using the same definition, but inserting the modifier “primarily”).

sociopolitical deviance as a mental disorder.¹⁹⁶ In most jurisdictions, political affiliation is not a protected class;¹⁹⁷ a private employer can, in most cases, make employment decisions based on an employee's political affiliation. However, if holding radical sociopolitical philosophy beliefs can establish a mental health disorder, then a Neopaganist¹⁹⁸ could claim that his pro-racist, pro-Nazi beliefs are part of a mental health disorder and seek protection under the ADA.¹⁹⁹

In recent years, news reports have highlighted a British poll²⁰⁰ and an American Academy of Pediatrics report in the journal *Pediatrics*²⁰¹ that discussed the empirically questionable "Internet Addiction Disorder." Internet Addiction Disorder was originally proposed as a satirical hoax by Dr. Ivan Goldberg in 1995, modeled after the DSM-IV's diagnostic criteria for pathological gambling.²⁰² Despite the general lack of support in medical

¹⁹⁶ See *supra* note 129. 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.

¹⁹⁷ See, e.g., Ill. Human Rights Act, 775 ILCS 5/1-102 (2012) (defining protected classes).

¹⁹⁸ See generally Helen A. Berger, WITCHCRAFT AND MAGIC: CONTEMPORARY NORTH AMERICA (Univ. of Penn. Press 2006) (discussing neopaganism and its pro-racist and pro-Nazi sects).

¹⁹⁹ In theory, this definition could stretch further to "Birthers," conspiracy theorists, Holocaust deniers, or any manner of sociopolitical beliefs outside the "mainstream."

²⁰⁰ 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 YouGov 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").

²⁰¹ Dr. Gwenn Schurgin O'Keefe & Dr. Kathleen-Clarke-Pearson, *Clinical Report—The Impact of Social Media on Children, Adolescents, and Families*, 127 PEDIATRICS 800 (2012), available at <http://pediatrics.aappublications.org/content/early/2011/03/28/peds.2011-0054.full.pdf+html>.

²⁰² Dr. Ivan Goldberg, Posting to PSYCOM.NET (Mar. 16, 1995, 5:06 PM), available at <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>.

studies for this addiction,²⁰³ the American Psychiatric Association is nonetheless considering adding the disorder category to the DSM-5.²⁰⁴

The Task Force is also considering the addition of conditions that outside sources suggested, such as “Apathy Syndrome,” “Internet Addiction,” and “Seasonal Affective Disorder” as psychiatric disorders.²⁰⁵ Medical literature defines apathy syndrome is “a syndrome of primary motivational loss, that is, loss of motivation not attributable to emotional distress, intellectual impairment, or diminished level of consciousness.”²⁰⁶ 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,” the proposals reflect a fundamental change in the DSM that may make necessitate the legal community removing the Manual from its current lofty perch of authority. The proposals reflect the DSM’s continued move towards a spectrum model of mental illness.²⁰⁷ This involves “the clustering of disorders into illness spectra (e.g., psychotic, bipolar, cognitive) and extension farther into the softer end of

²⁰³ See, e.g., Dr. John M. Grohol, *Pediatrics Gets It Wrong About ‘Facebook Depression’*, PSYCHCENTRAL (Mar. 28, 2012), <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*).

²⁰⁴ See *supra* note 148. 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 Fed. Appx. 128 (2d Cir. 2010).

²⁰⁵ See *supra* note 148.

²⁰⁶ RS Marin, *Apathy: A Neuropsychiatric Syndrome*, 3 J. NEUROPSYCHIATRY & CLINICAL NEUROSCIENCE 243-54 (1991). The DSM-5 site does not include definitions for these disorders, indicating that the work groups are “further assessing the evidence” before making a recommendation. See *supra* note 148.

²⁰⁷ Frances, *supra* note 124; see also Joseph M. Pierre, *The Borders of Mental Disorder in Psychiatry and the DSM: Past, Present, and Future*, 16 J. PSYCHIATRIC PRAC. 375, 379 (2010) (discussing the DSM’s spectral model and the in the context of personality disorders).

these spectra,”²⁰⁸ 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.”²⁰⁹ This paper agrees with both medical and non-medical critics who contend that the proposed DSM-5 will create millions of new diagnosed “illnesses,” whether they exist medically (or legally) or not. Dr. Frances writes, 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-V net.”²¹⁰ The cost extends to the legal community as well.

The threshold coverage issue of “disability” has been defined into virtual irrelevance under the ADAAA, the EEOC’s regulations, and recent case law. 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 ADAAA’s definition of “disability,” costing employers as much as \$235 million per year over five years for additional accommodations.²¹¹ 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

²⁰⁸ Pierre, *supra* note 207.

²⁰⁹ Allen Frances, *A Warning Sign on the Road to DSM-5: Beware of its Unintended Consequences*, PSYCHIATRIC TIMES (June 26, 2009), [http:// www.psychiatrictimes.com/dsm-5/content/article/10168/1425378](http://www.psychiatrictimes.com/dsm-5/content/article/10168/1425378).

²¹⁰ *Id.*

²¹¹ *See* 74 Fed. Reg. 48437 (ADAAA proposed regulations).

the relative wisdom of the DSM-5 approach for the medical community, the “spectralization” of mental illness²¹² means that legal practitioners, including courts and government agencies, must take seriously the admonitions in the DSM-IV²¹³ (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.²¹⁴

Even under the ADAAA, medical diagnoses do 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.’”²¹⁵ Instead, the DSM-IV reminds the legal community that, “[w]hen used appropriately, diagnoses and diagnostic information can *assist* decision makers in their determinations.”²¹⁶

As courts have noted, only with “additional information . . . beyond that contained in the DSM[] diagnosis” can we determine whether an individual’s impairment meets any particular legal standard.²¹⁷ Although the statement was removed from the EEOC’s final regulations, the courts in particular should be reminded of the proposed regulations’ statement that disability

²¹² See *Pierre*, *supra* note 207.

²¹³ See *supra* notes 30-37, 68 and accompanying text.

²¹⁴ See, e.g., *Rolland v. Potter*, 492 F.3d 45 (1st Cir. 2007); *Squibb v. Memorial Med. Ctr.*, 497 F.3d 775 (7th Cir. 2007); *Dattoli v. Principi*, 332 F.3d 505 (8th Cir. 2003); *Taylor v. Pathmark Stores, Inc.*, 177 F.3d 180, 186-87 (3rd Cir. 1999); *Talk v. Delta Airlines, Inc.*, 165 F.3d 1021, 1025 (5th Cir. 1999).

²¹⁵ DSM-IV, *supra* note 1, at xxxiii

²¹⁶ DSM-IV, *supra* note 1, at xxxiii.

²¹⁷ *Bercovitch v. Baldwin Sch., Inc.*, 133 F.3d 141, 155 n.18 (1st Cir. 1998).

determinations “often may be made using a common-sense standard, without resorting to scientific or medical evidence.”²¹⁸ In 1998, the Sixth Circuit noted in dicta that “[t]he 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.”²¹⁹ 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,²²⁰ employers and employees cannot avoid the consequences of the American Psychiatric Association’s decisions. Outside the courts, the “spectralized” DSM-5 combined with the lower standards in the ADA AAA 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 ADA AAA or at least raise enough fact-intensive issues to lead to more extensive (and expensive) discovery, and more cases that proceed 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 to failure to accommodate claims and the uncertainty of litigation.²²¹

²¹⁸ 74 Fed. Reg. 48440 (2009)

²¹⁹ *Wade v. Gen. Motors Corp.*, 165 F.3d 29 (table), 1998 WL 639162, at *2 (6th Cir. Sept. 10, 1998).

²²⁰ See *supra* note 141.

²²¹ Of course, even if employers have no *legal* obligation to accommodate certain employees, employers should consider affording reasonable accommodations of one sort or another anyways. 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.

Regardless of what the DSM-5 Task Force finally adopts, 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 likely 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 to failure to accommodate claims, and focus both parties on the issues most relevant to post-ADAAA litigation (whether the employee is “qualified” and what motivations the employer has for its actions).

This Article has cast a critical eye on the proposed DSM-5. While the Manual is only at the proposal stage, the proposed additions and the general reduction in diagnostic criteria for common disabilities cited in ADA and FMLA cases such as Major Depressive Disorder and Generalized Anxiety Disorder bear close scrutiny as the May 2013 publication deadline approaches.