DSM-5 and the Law

Changes and Challenges

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CHAPTER 8

DSM-5 and Personal Injury Litigation

INTRODUCTION

Civil litigation is a major aspect of the legal system in the United States, marked by a vast number and variety of cases. According to census data from 2008, more than 19 million civil cases were filed in state trial courts in that year alone. In the U.S. District Courts, 285,215 civil cases were filed in 2010, with 87,256 of those involving tort actions [1, 2]. Even if cases involving psychiatry represent only a small percentage of these civil actions, they nevertheless encompass a significant number of evaluations in which a forensic evaluator's expertise is vital. It stands to reason that changes in how mental disorders are diagnosed portend significant implications for assessing how alleged harms are assessed under tort law.

Tort law governs the legal resolution of complaints regarding medical treatment and alleged personal injury. A tort is a civil wrong. Tort law seeks to financially compensate individuals who have been injured or who have suffered losses due to the conduct of others. Intentional torts are those where the individual or agency intends harms or knows harm will result form his or her actions [3]. In contrast, unintentional torts involve those situations in which the individual's behavior unintentionally causes an unreasonable risk of harm to another [3]. Depending on the type of civil litigation, claims of emotional distress can include a claim of intentional infliction of emotional distress and/or a claim of negligent (i.e., unintentional) infliction of emotional distress.

When evaluating alleged emotional damages arising during the course of civil litigation, the evaluator generally considers the elements summarized in Table 8-1.

This chapter summarizes how DSM-5 diagnostic changes may impact the assessment of claims of emotional distress and psychiatric injury in medical

Table 8-1. RELEVANT QUESTIONS TO CONSIDER WHEN EVALUATING EMOTIONAL DISTRESS CLAIMS

1. Does the person meet criteria for a recognized mental disorder?
2. If the person does not meet criteria for a recognized mental disorder, is there evidence that the individual genuinely experienced some type of emotional distress?
3. Is there evidence that the person is malingering?
4. Does the evidence support that the alleged stressor is solely responsible for the reported symptoms?
5. Is there evidence that the person has a preexisting mental disorder?
6. If the person has a preexisting mental disorder, does the evidence indicate that the alleged stressor is nevertheless solely responsible for the reported symptoms?
7. If the person has a preexisting mental disorder, does the evidence support that the alleged stressor aggravated the preexisting mental disorder?
8. Are there other factors that are causally related to the reported symptoms independent of the alleged stressor?

malpractice and personal injury litigation. In addition, the impact of DSM-5 substance use disorder criteria on civil litigation involving "addiction" is highlighted.

MEDICAL MALPRACTICE CLAIMS

Overview

Medical malpractice claims can involve intentional or unintentional torts. Examples of intentional torts that involve mental healthcare include assault (an attempt to inflict bodily injury), battery (touching without consent), false imprisonment, and violation of a person's civil rights. In some circumstances, failure to give informed consent regarding a medication's potential side effects can be considered a battery because the person's body was "touched" without their consent.

Negligent torts are often referred to as claims of malpractice (i.e., medical negligence). Negligent torts are the most common type of malpractice claim that involves patient care. The four elements required to establish medical negligence are generally known as the "four Ds." These are a *Dereliction* of *Duty* that *Directly* results in *Damages*. A duty is most commonly established for a clinician when the patient seeks treatment and treatment is provided. Dereliction of duty is usually the most difficult component of negligence for the plaintiff to establish. Two aspects of causation generally cited as establishing negligence in medical malpractice cases include the foreseeability of the harm and the clinician's role in directly causing the harm. *Damages* are the amount of money the plaintiff is awarded in a lawsuit.

DSM-5 and civil litigation related to risk assessment

Many malpractice claims involve an allegation that the patient was not appropriately diagnosed, which could be a dereliction of duty if proved true. Practitioners who fail to utilize the DSM-5 may face allegations (justly or unjustly) that they fell below the standard of care in making a diagnosis. In particular, a failure to appropriately diagnose may be linked to failures to identify and potentially treat mental health risk factors associated with an increased risk of suicide or violence. In DSM-IV, many disorders, such major depressive disorder and schizophrenia, included descriptions of suicide risk under the subheading "Associated Features and Disorders." This focus is expanded in DSM-5, with a separate subheading labeled "Suicide Risk" for 25 different mental disorders. Suicide risk was *not* emphasized in many of these disorders in DSM-IV. The subheading of Suicide Risk is different for each disorder, but it typically includes information about the level of risk associated with the disorder, common risk factors for suicide, and comorbid disorders that may further increase suicide risk. This information may impact civil litigation, particularly malpractice cases, because it demonstrates a greater focus in the DSM-5 on considering suicide risk in clinical practice and provides some guidance that attorneys may use as evidence of the "standard of care."

Although suicide risk was separated into a new subheading, discussions of violence risk remain relatively unchanged in DSM-5 compared to DSM-IV. Certain disorders, such as schizophrenia, provide information about violence risk in the subheading "Associated Features Supporting Diagnosis." These descriptions of violence risk are less consistently documented in the DSM-5 text and provide less guidance for the clinician or forensic evaluator than the text describing suicide risk.

DSM-5 and civil litigation related to prescribed medications

DSM-5 diagnostic categories specific to potential harms that may be caused by medications include medication-induced mental disorders and medication-induced movement disorders. These diagnostic categories are reviewed below, because they represent potential sources of malpractice claims against medication prescribers.

Medication-induced mental disorders

In DSM-5, there are two different types of medication-induced disorders described: those considered mental disorders (called substance/medication-induced) and those not considered as mental disorders (called

medication-induced movement disorders and other adverse effects of medication). The medication-induced mental disorders include substance/medication–induced psychotic disorder, bipolar and related disorder, depressive disorder, anxiety disorder, obsessive-compulsive and related disorder, sleep disorder, and sexual dysfunction. Many of the medication-induced mental disorders were included under the "Substance-Induced" diagnostic category in DSM-IV.

In both DSM-IV and DSM-5, Criterion A describes mental health symptoms that must be present to make the diagnosis. Compared with other nonsubstance/medication-induced disorders in the same diagnostic categories, the substance/medication-induced mental disorders and their DSM-IV counterparts generally require fewer symptoms to establish the diagnosis. For example, the DSM-5 diagnosis of substance/medication-induced depressive disorder requires "a depressed mood or markedly diminished interest or pleasure in all, or almost all, activities" [4 (p175)]. As a result, fewer symptoms are needed to establish a substance/medication induced depressive disorder diagnosis compared with the Criterion A of major depressive disorder, which requires five depressive symptoms.

DSM-5 also retains the suggestion that medications may *cause* a mental disorder, an important element in civil litigation. The previous diagnosis of "Substance-Induced" mental disorder in DSM-IV included medications as a potential substance that may cause symptoms, but DSM-5 brings the word "medication" into the title of the diagnosis. Although many similarities exist between the previous diagnoses and the ones present in DSM-5, there are also multiple criteria changes that may impact their use in forensic psychiatry.

The first change in substance/medication-induced mental disorders is in the diagnostic categories themselves. DSM-5 separates obsessive-compulsive and related disorders out from anxiety disorders and similarly separates bipolar and related disorders and depressive disorders into their own categories, instead of using the general mood disorders designation. Because these are now separate entities, the substance/medication-induced mental disorders in these categories reflect a different diagnosis for each.

Second, in the transition from DSM-IV to DSM-5, some of the language of Criterion A in the substance/medication-induced mental disorders has changed, mainly to add or subtract mention of clinical significance of symptoms. Many of these changes are not particularly significant because both the DSM-IV and DSM-5 versions of these diagnoses retain Criterion E, which requires clinically significant distress or impairment. The exception to this is the diagnosis of substance/medication-induced psychotic disorder. In DSM-IV, the equivalent diagnosis noted the following: "Do not include hallucinations if the person has insight that they are substance induced" [5 (p342)]. This statement is not retained in DSM-5, indicating an expansion of the criteria to include hallucinations that the individual knows are caused by the substance

or medication. DSM-IV also did not include Criterion E (i.e., clinically significant distress or impairment) for the diagnosis of substance-induced psychotic disorder, but this criterion is present in the DSM-5 version.

The third major change is perhaps the most relevant to forensic psychiatry. In DSM-IV, Criterion B for the substance-induced mental disorders required *either* of two criteria. The diagnosis of substance-induced mood disorder provides an example:

1. The symptoms in Criterion A developed during, or within a month of, substance intoxication or withdrawal.
2. Medication use is etiologically related to the disturbance [5 (p409)].

DSM-5 narrows this criterion and changes the language, stating that *both* of the following criteria must be present:

1. The symptoms in Criterion A developed during or soon after substance intoxication or withdrawal or after exposure to a medication.
2. The involved substance/medication is capable of producing the symptoms in Criterion A [4 (p175)].

These changes may affect the diagnosis of substance/medication-induced mental disorders in a significant way. A forensic evaluator now needs to provide both evidence of a medication's capability of producing a symptom and evidence that the symptom occurred around the time of exposure to the medication. Case reports alone are generally insufficient evidence by themselves to conclude that a medication causes a particular symptom.

The last major change in substance/medication-induced mental disorders is noted in Criterion C. Both the DSM-IV and DSM-5 use Criterion C to provide instructions as to how one may distinguish a substance or medication induced mental disorder from a primary mental disorder. However, one of these instructions has been removed from the DSM-5. The instruction removed from DSM-IV and *not* included in DSM-5 reads as follows: "the symptoms . . . are substantially in excess of what would be expected given the type or amount of the substance used or the duration of use . . ." [5 (p483)]. Unfortunately, this deletion ignores the reality that the dose and duration of the medication is often very relevant in considering the ability of the medication to induce symptoms.

Medication-induced movement disorders

The other set of medication-induced disorders described in DSM-5 are medication-induced movement disorders and other adverse effects of

medication. This category was present in DSM-IV (called medication-induced movement disorders), although it was placed in the section labeled "Other Conditions That May Be a Focus of Clinical Attention." In DSM-5, the category of medication-induced movement disorders and other adverse effects of medication has been moved into its own section. Diagnoses in this section include neuroleptic-induced parkinsonism, other medication-induced parkinsonism, neuroleptic malignant syndrome, medication-induced acute dystonia, medication-induced acute akathisia, tardive dyskinesia, tardive dystonia, tardive akathisia, medication-induced postural tremor, other medication-induced movement disorder, and antidepressant discontinuation syndrome.

DSM-5 clearly documents that these medication-induced movement disorders are not mental disorders, which differentiates them from substance/medication-induced mental disorders. In the description of this category of diagnoses, the DSM-IV and DSM-5 text are mostly the same. One important area where both versions retain the exact same language is the following:

> Although these disorders are labeled "medication induced," it is often difficult to establish the causal relationship between medication exposure and the development of the movement disorder, especially because some of these movement disorders also occur in the absence of medication exposure [4 (p709)].

The language used can be a critical distinction for a forensic evaluator, because the diagnosis alone does not necessarily mean the medication *caused* the symptoms described. This approach differs from substance/medication-induced mental disorders, which presume that the medication causes the described symptoms when making the diagnosis.

DSM-5 adds a new diagnosis to this section called antidepressant discontinuation syndrome. This condition is described as follows:

> A set of symptoms that can occur after an abrupt cessation (or marked reduction in dose) of an antidepressant medication that was taken continuously for at least 1 month. Symptoms generally begin within 2-4 days and typically include specific sensory, somatic, and cognitive-emotional manifestations [4 (p712)].

DSM-5 notes that frequently reported symptoms of antidepressant discontinuation syndrome include experiencing flashes of light, "electric shock" sensations, nausea, hyperresponsivity to noises or lights, nonspecific anxiety, and feelings of dread [4 (p713)]. DSM-5 emphasizes that to establish the diagnosis of antidepressant continuation syndrome, the evaluator should assess whether the reported symptoms were present before the antidepressant dosage was reduced and whether or not reported withdrawal symptoms are alleviated by restarting the same medication or starting a different medication

that has a similar mechanism of action. In the diagnostic features section, DSM-5 indicates that unlike withdrawal syndromes from other substances, antidepressant discontinuation syndrome has no distinct symptoms, which distinguishes it from other substance withdrawal disorder diagnoses.

PERSONAL INJURY CLAIMS

Personal injury claims are wide-ranging and can involve claims that a person experienced emotional distress or a psychiatric injury (such as a mental disorder or diagnosis) as a result of an accident, sexual harassment, discrimination, or exposure to a toxic agent. The following vignette presents a typical case involving a person reportedly injured in a motor vehicle accident with the subsequent application of new DSM-5 criteria to consider when assessing his claims.

VIGNETTE

Mark is a 45-year-old married computer software sales representative who is leaving work when he is rear-ended by another car that is going less than 35 miles per hour. Mark is wearing his seat belt but his air bag does not deploy. He is able to get out of the car without assistance. He calls his wife to tell her that he has been in an accident and she becomes immediately emotionally distraught, wrongly believing that Mark was nearly killed and suffered great injuries. Mark is fully alert without evidence of any injury and with a Glasgow Coma Score of 15. Mark is taken to the emergency room where a computed tomography scan of the head is normal and his physical examination is completely unremarkable. He tells the emergency room physician that he did not lose consciousness or hit his head. Mark complains of back and neck pain and he is diagnosed with "neck and back strain." He is discharged home with instructions to follow up with his primary care provider, and a 10-day supply of diazepam and hydrocodone is provided. Over the next several days, Mark reports increasing back and neck pain with numbness and tingling in his legs. Over the subsequent two-year period, he undergoes repeated tests and various scans that do not find a cause for his leg numbness and weakness. One magnetic resonance imaging scan shows some potential narrowing of the vertebral columns, and Mark is told that he may have sustained "damage to his spinal cord." He believes this finding explains all of his symptoms, and he becomes extremely worried about its implications. He reports persistent severe pain, despite physical therapy and various medication trials. He spends a great deal of time

visiting doctors and surgeons, and he is anxious he will never "return to normal." Mark is reluctant to go out with his family to dinner due to fear that he will "strain his back" and his pain will worsen.

Mark does not have any known prior history of mental health disorders. A review of Mark's history indicates that at the time of the accident, he also had multiple other life stressors, including serious marital problems. On the afternoon of the accident, just moments before he got into the car to leave work, he learned that his job was in jeopardy due to corporate downsizing.

Mark sues the insurance company of the driver who hit him for severe emotional distress. In his complaint, he alleges that he suffers severe pain, fatigue, dizziness, depression, nightmares of the accident, fear of driving, persistent headaches, numbness and tingling in his legs, and marked problems with his concentration and memory. He also reports that there has been a significant change in his personality, to include marked irritability and sudden mood changes. Mark recently resumed working in a job similar to his prior job, but he emphasizes that he has to exert greater effort to successfully perform his job duties.

Mark's reported symptoms are commonly seen in personal injury accident litigation and encompass a wide range of potential diagnoses. Those DSM-5 diagnoses that are particularly relevant when considering Mark's legal complaint are summarized below with a focus on DSM-5 diagnostic changes and/or additions to the DSM-IV.

Depressive disorders

Major depressive disorder criteria are essentially unchanged from DSM-IV, and the DSM-5 diagnosis of persistent depressive disorder includes the DSM-IV diagnoses of chronic major depressive disorder and dysthymic disorder. Although the evaluator will need to carefully determine whether Mark meets criteria for a DSM-5 depressive disorder, DSM-5 does not make substantial changes to this diagnostic category that warrants further discussion here.

Somatic symptom and related disorders

DSM-IV emphasized that somatoform disorders were characterized by the presence of physical symptoms when an underlying medical condition could *not* be determined. DSM-5 abandons this approach. Instead, the DSM-5

somatic symptom and related disorders focus on the distress or life disruption caused by the person's physical illness or their worries of becoming physically ill, *with or without* an identified medical cause. The DSM-IV diagnoses of somatization disorder, hypochondriasis, pain disorder, and undifferentiated somatoform disorder are replaced in DSM-5 by newly named or newly included disorders, which are summarized below and applied to Mark's case.

Somatic symptom disorder

In somatic symptom disorder, Criterion A describes that the person experiences one or more physical symptoms that cause distress or significant life disruption. Although persons with somatic symptom disorder often have multiple somatic symptoms, the DSM-5 highlights that the diagnosis can also be made if "only one severe symptom, most commonly pain, is present" [4 (p311)]. DSM-5 specifically notes that "the individual's suffering is *authentic* [emphasis added] whether or not it is medically explained." This particular statement does not take into consideration situations when there is no underlying medical condition and the person is malingering or feigning their physical symptoms. In this situation, their suffering would *not* be authentic, and the forensic evaluator needs to make this clear in their assessment. Furthermore, for unclear reasons, DSM-5 does not list either malingering or factitious disorder in the differential diagnosis of somatic symptom disorder, although both were noted in the differential diagnosis for the DSM-IV diagnoses of somatization disorder, undifferentiated somatoform disorder, and pain disorder.

Criterion B focuses on whether or not the person has experienced excessive thoughts, feelings, or behaviors related to their somatic symptoms or associated health concerns. The qualifier "excessive" is not defined and is likely to have different subjective interpretations by examiners. In Mark's case, if he has been told that his narrowing of his vertebral columns is the cause of his pain, at what point does his spending time and energy to achieve pain relief become "excessive"? DSM-5 provides three presentations that indicate the individual is demonstrating "excessive" thoughts, feelings, or behaviors. Only one of these three presentations must be met (for a period greater than six months) to satisfy the B criterion. The three presentations (quoted exactly) are as follows:

1. Disproportionate and persistent thoughts about the seriousness of one's symptoms.
2. Persistently high level of anxiety about health or symptoms.
3. Excessive time and energy devoted to these symptoms or health concerns [4 (p311)].

When reviewing the above three presentations, both forensic evaluators and clinicians should attempt to quantify how much a person thinks about their symptoms, how much time and energy they spend related to their symptoms, and how much they worry about their symptoms. Structured assessments that rate the degree of anxiety a person experiences (e.g., Beck Anxiety Inventory [6]) may be useful adjuncts to the clinical examination.

DSM-5 includes the specifier "with predominant pain" for somatic symptom disorder. As a result, the diagnosis of "somatic symptom disorder with predominant pain" is the effective equivalent of the DSM-IV pain disorder diagnosis. Based on Mark's presentation, he will likely qualify for somatic symptom disorder, with predominant pain if the evaluation indicates that he is not malingering or feigning.

Illness anxiety disorder

In contrast to somatic symptom disorder, the newly added DSM-5 illness anxiety disorder describes a person who is preoccupied with having or acquiring a serious illness with *minimal*, if any, somatic symptoms. If there are somatic symptoms, they are mild in intensity and the person's preoccupation with their risk for becoming ill is "clearly excessive or disproportionate." As with somatic symptom disorder, the determination of when a person's preoccupation is "excessive" or "disproportionate" will likely involve some subjective interpretation. For example, consider the case of Jane, a 26-year-old woman who works in a fertilizer plant and is potentially exposed to toxic fumes after a plant explosion. Although her physical examination is normal, she repeatedly checks her body for any "rashes and lesions" and becomes highly anxious about her health, despite no evidence or symptoms to suggest she is ill. Would all examiners assess her behaviors as excessive and disproportionate? How does one determine the dividing line between normal concern and excessive worry?

In Mark's case, he will not likely meet criteria for illness anxiety disorder because he has multiple significant health complaints that are above and beyond the minimal somatic symptom limitation noted in illness anxiety disorder.

Conversion disorder

In DSM-5, conversion disorder is also named "functional neurological symptom disorder." In both the DSM-IV and DSM-5, individuals with conversion disorder typically present with symptoms that suggest altered motor or sensory function. However, DSM-5 has three important changes that

impact how conversion disorder is now diagnosed. First, DSM-5 eliminates DSM-IV's requirement that "psychological factors are judged to be associated with the symptom or deficit . . ." [5 (p498)]. No longer does the evaluator need to opine that a psychological factor, such as an overwhelming emotional stress, resulted in the person's sensory/motor loss. DSM-5 recognizes that conversion disorder symptoms may be associated with stress or trauma but specifically states "the diagnosis should not be withheld if none is found" [4 (p320)]. Second, DSM-5 abandons the DSM-IV requirement that produced symptoms are not intentionally produced or feigned because "the definite absence of feigning may not be reliability discerned" [4 (p320)]. However, unlike the diagnoses of somatic symptom disorder and illness anxiety disorder discussed above, DSM-5 includes factitious disorder and malingering in the differential diagnosis for conversion disorder. Third, DSM-5 adds the following diagnostic criteria: "Clinical findings provide evidence of incompatibility between the symptom and recognized neurological or medical conditions" [4 (p318)]. To establish this criterion, the evaluator should carefully evaluate any presentation inconsistencies, particularly in civil litigation cases. Such inconsistencies include varying statements from the individual about the onset and nature of reported symptom, contradictory symptom presentations in the medical records, and inconsistent presentation of symptoms during the examination.

DSM-5 provides two specifiers for conversion disorder: "with psychological stressor" and "without psychological stressor." Although the use of the "with psychological stressor" specifier implies that the stressor may have *caused* the conversion disorder, the DSM-5 text seems to caution against this assumption when it writes, "the *potential* etiological relevance of this stress or trauma may be *suggested* by a close temporal relationship" [4 (p320)] [emphasis added]. Therefore, the examiner should not automatically assume that the litigated stressor caused the conversion disorder if one is diagnosed. In Mark's case, his marital stress and recent potential job loss could also account for his somatic and conversion disorder symptoms.

Psychological factors affecting other medical conditions

This disorder is newly placed in the DSM-5 chapter on Somatic Symptom and Related Disorders. In DSM-IV, this disorder was included under "Other Conditions that May be the Focus of Clinical Attention." Its move to Section II of DSM-5 elevates this condition to the status of a fully recognized mental disorder. In DSM-IV, this diagnosis emphasized how the presence of one or more psychological or behavioral factors could adversely impact a "general medical condition" [5 (p731)]. The DSM-5 text likewise emphasizes this connection in the text that reads:

> There must be reasonable evidence to suggest an association between the psychological factors and the medical condition, although it may often not be possible to demonstrate causality or the mechanisms underlying the relationship [4 (p323)].

In the forensic context, this text indicates that the evaluator should have some credible data to link how psychological factors impact the person's medical condition. In Mark's case, it is unclear if and how psychological factors adversely affect his somatic symptom presentation. To help make this distinction, the evaluator assesses whether Mark's pain worsens *after* he experiences some psychological or behavioral symptom (such as being depressed, irritable, or angry). DSM-5 notes that in situations in which the person's psychological or behavior reaction occurs *in response to* the medical condition, the more appropriate diagnosis would be adjustment disorder. However, in Mark's case, his intense focus and worry about his somatic symptoms and pain are more consistent with a diagnosis of somatic symptom disorder as opposed to an adjustment disorder alone.

The DSM-IV text focused on recognized medical conditions from a broad range of disease categories that may be adversely impacted by psychological factors. In contrast, DSM-5 Criterion A reads, "a medical *symptom* or condition . . . is present" [4 (p322)] [emphasis added]. DSM-5 significantly expands the DSM-IV definition of a medical condition, as illustrated by the following text:

> Affected medical conditions can be those with clear pathophysiology (e.g., cancer, coronary disease), functional syndromes (e.g., migraine, irritable bowel syndrome, fibromyalgia), or idiopathic medical symptoms (e.g., pain, fatigue, dizziness) [4 (p322)].

Under this broadened definition, *unexplained* fatigue or pain is now considered a medical condition. To distinguish this presentation from somatic symptom disorder, DSM-5 notes that the individual suffering from the diagnosis of "psychological factors affecting other medical condition" does not present with excessive worries or anxious behaviors in regard to their physical complaint.

Factitious disorder

In DSM-IV, Factitious Disorder had its own separate chapter. DSM-5 has moved this disorder into the Somatic Symptom and Related Disorders chapter because of the predominance of somatic symptom complaints and presentation of the individual in medical settings. In addition, DSM-5 adds a

D criterion, which reads, "The behavior is not better explained by another mental disorder, such as delusional disorder or another psychotic disorder" [4 (p324)]. Although Mark has sought out treatment with multiple medical personnel, there is no evidence from the record that he is taking surreptitious actions to cause his symptoms making a diagnosis of factitious disorder highly unlikely.

Trauma- and stressor-related disorders

Posttraumatic stress disorder

Traumatic events are a widespread phenomenon, with the vast majority of Americans exposed to at least one throughout their life [7]. In civil litigation, a plaintiff's exposure to a stressor is often alleged to have caused posttraumatic stress disorder (PTSD) or some other type of emotional distress or disorder. In reality, PTSD is an uncommon outcome for persons exposed to a traumatic stressor. In one study, only 23.6% of persons exposed to a traumatic event went on to develop PTSD [8].

PTSD was formally introduced as a diagnosis in the DSM-III [9]. PTSD Criterion A defines what constitutes a traumatic event, and this definition has evolved in its scope and language with the release of each DSM edition. Altering the definition of a traumatic stressor can change what type of trauma is sufficient to warrant a PTSD diagnosis. In the DSM-III, Criterion A reads, "The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone" [9 (p238)]. This definition was considered an "objective" standard because the traumatic event required to produce PTSD had to be distressing to most people (as opposed to a single individual). In contrast, the DSM-IV Criterion A reads, "The person experienced or witnessed or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" [5 (p467)]. This definition is considered a "subjective standard" because the focus is on how an individual person, not a group at large, perceives an event. Ameringen et al. [10] reviewed the impact of the DSM-IV altering the DSM-III A criterion and found that this wording change led to a 2% increase in the rate of PTSD diagnosis.

If past revisions to the DSM criteria can change the prevalence of PTSD, how might such changes impact the resulting legal aspects of being diagnosed with PTSD? Dr. Alan Stone famously stated that, "No diagnosis in the history of American psychiatry has had a more dramatic impact on law and social justice than post-traumatic stress disorder" [11]. Stone [11] proposed that the diagnosis of PTSD has far reaching aspects in both the criminal and civil arenas. For instance, Stone [11] writes that in civil litigation,

the adding of PTSD to the DSM-III opened the door for damages of "purely psychic injury," whereas courts were previously reluctant to award damages without an accompanying tangible physical injury [11]. If the introduction of PTSD as a new mental disorder had such far reaching consequences, then what might be the impact of DSM-5's new PTSD diagnostic criteria on the frequency of PTSD claims in civil litigation? The following sections outline key criterion changes that the DSM-5 makes to the diagnosis of PTSD, which is now included in a separate section titled "Trauma- and Stressor-Related Disorders."

DSM-5 PTSD Criterion A: The traumatic stressor defined

Although there are multiple changes from DSM-IV to DSM-5, the presence of a trauma preceding symptoms continues to be a required criterion of PTSD. However, the definition of what constitutes a trauma has evolved with DSM-5 in meaningful ways. First, DSM-5 removes the requirement that a person's reaction to an event involves "intense fear, helplessness, or horror" at the time of the event. Friedman writes that presence or absence of a person's reaction is not predictive of PTSD outcome and therefore irrelevant in making a PTSD diagnosis [12].

Second, Criterion A notes that the person must have "exposure to actual or threatened death, serious injury, or sexual violence" [4 (p271)]. This definition now includes "sexual violence," which was *not* specified under DSM-IV criteria. Gone, however, is DSM-IV's wording that allowed a person to qualify as being exposed to a traumatic event if he or she experienced a "threat to the physical integrity of self or others" [5 (p467)]. This deletion may impact how frequently PTSD can be diagnosed in civil litigation cases that involve a sexual harassment claim. For example, under DSM-IV, a plaintiff alleging sexual harassment could claim that the alleged harasser represented a threat to their "physical integrity," even if there was no actual or threatened death or serious injury. Because the DSM-5 wording indicates that there must be actual or threatened death, serious injury, or sexual violence, cases in which this level of trauma exposure is not present (as is often seen in sexual harassment cases) will *not* likely qualify for PTSD. Furthermore, DSM-5 has added a diagnosis titled "Other problem related to employment" in the section titled "Other Conditions that May be a Focus of Clinical Attention" (a section that includes diagnoses that are *not* mental disorders). DSM-5 provides a range of work conditions considered as employment-related problems, and "sexual harassment on the job" is included among them [4 (p723)]. As a result of these DSM-5 diagnostic changes, an employee who reports emotional distress related to sexual harassment will more easily meet criteria for the diagnosis of "Other problem related to employment," as opposed to PTSD.

A third, and quite robust, change is the addition of two exposures that may qualify as a traumatic event (in addition to directly experiencing or witnessing the trauma). These two newly added exposures are as follows:

1. "Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or traumatic" [4 (p271)].
2. "Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse)." [Note: This criterion would not apply if the person was exposed to learning about the trauma through electronic media, television, movies, or pictures unless the exposure occurs as part of the person's work.] [4 (p271)]

These new trauma categories expand situations that qualify as a traumatic event and may lead to an increased number of individuals diagnosed with PTSD. With these new criteria, an individual can be diagnosed with PTSD without ever being present at the traumatic event. In Mark's case, the evaluator will try to determine if during his accident Mark was genuinely exposed to actual or threatened death or serious injury. With the new DSM-5 criteria, Mark's wife may now claim that when she learned of Mark's accident, she believed that his life had been threatened and he might die. Although DSM-5 expands the types of trauma exposures that qualify for a diagnosis of PTSD, these expansions are not without limits. In the case of learning about a traumatic event that occurred to a close family member or friend, the event must have been violent or traumatic. This restriction excludes the majority of deaths from natural causes; had this exclusion not been included, the number of individuals qualifying for traumatic event in Criterion A of DSM-5 would likely be much greater.

DSM-5 Criterion B: Presence of one or more intrusion symptoms

DSM-5 provides some changes in the criteria related to intrusive thoughts, which are enumerated in Criterion B, both in DSM-IV and DSM-5. In DSM-5, the DSM-IV term "distressing memories" is changed to "distressing recollections." DSM-5 specifies that these recollections are "involuntary" (a descriptor not included under DSM-IV), indicating that voluntary reflection of a traumatic event does not qualify as a PTSD symptom. DSM-5 rewords how distressing dreams are manifest, effectively expanding the range of dreams that satisfy this criterion. In particular, DSM-5 alters the description of recurrent, distressing dreams; previously, DSM-IV specified that the dreams were of the traumatic event. In DSM-5, the content and/or affect of

the dreams are *related* to the traumatic event(s). This change expands the criteria to include dreams that have some relationship to the traumatic event, but dreaming only about the event itself is no longer required.

Flashbacks, a symptom that many associate with PTSD, are retained in DSM-5 as Criterion B3. In DSM-IV, flashbacks were described as acting or feeling as if the traumatic event was recurring, along with a sense of reliving the experience, illusions, and hallucinations. Interestingly, DSM-IV also included that flashbacks and the other symptoms in Criterion B3 could occur "on awakening or when intoxicated" [5 (p468)]. By removing the description that symptoms could occur when intoxicated, DSM-5 further attempts to separate PTSD from comorbid substance use disorders, along with the new Criterion H. DSM-5 removes much of this description and instead sets flashbacks (or dissociative reactions) as the main symptom for this criterion and adds the following disclaimer: "Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings" [4 (p271)].

DSM-5 also broadens the definition of psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. In DSM-IV, psychological distress was required to be "intense"; DSM-5 describes that the distress can be "intense or prolonged." This change extends the criteria to consider not only the intensity of the psychological distress, but also the time course.

Although DSM-5 widens some criteria that may result in PTSD being more easily diagnosed, there is also new wording that seems to narrow some criteria. For example, under DSM-IV, Criterion B5 required "physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event" [5 (p468)]. DSM-5 adds the descriptor "marked" to the level of physiological activity, clearly indicating that a physical response upon trauma exposure must be significant rather than minimal or mild.

DSM-5 Criterion C: Persistent avoidance of stimuli associated with the traumatic event(s)

DSM-5 includes only two avoidance symptoms under Criterion C, in contrast to DSM-IV, which included seven. The two remaining DSM-5 symptoms focus on a person's avoidance of memories, thoughts, or feelings that are associated with the trauma and avoidance of external reminders that are associated with the trauma. Both of these symptoms are very similar to the first two avoidance symptoms listed under Criterion C in DSM-IV. However, DSM-5 eliminates the DSM-IV requirement that the individual have "numbing to general responsiveness" and instead the focus is solely on evaluating the person's persistent avoidance of stimuli.

Although this criterion is new to DSM-5 and was not delineated under DSM-IV, five of the seven listed symptoms were included under DSM-IV's Criterion C. DSM-5 Criterion D symptoms and their related DSM-IV counterparts are summarized in Table 8-2.

When reviewing Table 8-2, several important comparisons between the two DSM manuals become apparent. First, DSM-5 criteria D1, D5, and D6 are nearly identical to their DSM-IV Criterion C counterparts. Second, the DSM-IV equivalent to the DSM-5 D2 criterion described that the individual sensed they had a foreshortened future. The revised DSM-5 version expands such negative beliefs *beyond* the individual and now includes negative thoughts about others and the "the world" at large. However, the modifier "persistent" has been added when evaluating these beliefs, and this addition indicates that such thoughts are not brief or fleeting. Third, Criteria D3 and D4 are completely new to the DSM-5. Evaluators should now ask the individual about their personal feelings of guilt or responsibility related to the trauma and any persistent negative emotions they have experienced after the trauma. Finally, the DSM-5 D7 criterion modifies its DSM-IV equivalent by adding the modifier "persistent" when evaluating the extent of the individual's inability to experience positive emotions.

Table 8-2. DSM-5 D CRITERION: A MIXTURE OF DSM-IV AND DSM-5

DSM-5	DSM-IV
D1. Inability to remember an important aspect of the traumatic event (s).	C1. Inability to recall an important aspect of the trauma.
D2. Persistent and negative beliefs or expectations about oneself, others, or the world.	C7. Sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).
D3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.	Not included in the DSM-IV.
D4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).	Not included in the DSM-IV.
D5. Markedly diminished interest or participation in significant activities.	C4. Markedly diminished interest or participation in significant activities.
D6. Feelings of detachment or estrangement from others.	C5. Feeling of detachment or estrangement from others.
D7. Persistent inability to experience positive emotions.	C6. Restricted range of affect (e.g., unable to have loving feelings).

DSM-5 Criterion E: Marked alterations in arousal and reactivity

DSM-5 alters the arousal section to also include reactivity as part of the overall criterion, as well as noting that the arousal must be "marked." DSM-5 also clarifies that Criterion E symptoms must be related to the traumatic event; in DSM-IV, this relationship was not specified, but rather the symptoms simply had to be "not present before the trauma." This change focuses the evaluation so that only deficits in arousal and reactivity that are specifically related to the trauma can be counted toward a PTSD diagnosis. As a result, the evaluator should carefully determine which reported symptoms are preexisting or unrelated to the traumatic event. Finally, DSM-5 adds a symptom of "reckless of self-destructive behavior" to this section, which was not previously present in DSM-IV.

Other DSM-5 PTSD components

DSM-5, like DSM-IV, requires that symptoms last at least one month to qualify for a PTSD diagnosis. In addition, DSM-5 maintains the requirement that "the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning," which had been added to the DSM-IV PTSD criteria [4 (p272)]. DSM-5 includes a new criterion that emphasizes that PTSD can not be diagnosed if the symptoms are due to the physiological effects of a substance or another medical condition. DSM-5 removes the specifiers of "acute" and "chronic" from the criteria for PTSD. Instead, DSM-5 adds a "with dissociative symptoms" specifier, which is used when an individual experiences persistent or recurrent symptoms of depersonalization or derealization. DSM-5 renames the specifier "with delayed onset" to "with delayed expression." In the new criteria, delayed expression is given when the person does not meet full diagnostic criteria for PTSD until at least six months after the event. This change reflects that some PTSD symptoms may occur immediately but full expression of symptoms can be delayed. DSM-5 includes separate descriptors for PTSD for children six years or younger. Finally, for unclear reasons, DSM-5 has removed DSM-IV's consideration of malingering in the differential diagnosis of PTSD. Considering that PTSD is one of the most common diagnoses alleged in civil litigation, this elimination is ill advised, and the forensic evaluator should continue to carefully evaluate for the possible exaggeration or feigning of symptoms, particularly in a forensic context.

Acute stress disorder

Acute stress disorder is also listed in the Trauma-and Stressor-Related Disorders section and has the same A criterion as the DSM-5 diagnosis of

PTSD. DSM-5 made the following changes to the DSM-IV diagnosis of Acute Stress Disorder, in addition to the PTSD Criterion A change, outlined above. First, DSM-5 is much more specific in identifying specific symptoms that characterize acute stress disorder. Second, DSM-5 requires at least nine of 14 symptoms from any of the five identified categories (intrusion, negative mood, dissociation, avoidance, and arousal) that begin or worsen after the trauma exposure in order to make an acute stress disorder diagnosis. DSM-5 does not require a specific number of symptoms from *each* of the five categories-only a *total* of nine symptoms is required. As a result, a person can experience *no* arousal symptoms yet still meet criteria for acute stress disorder if they have sufficient symptoms in the other categories. Likewise, under this new diagnostic scheme, a person can experience *no* intrusion symptoms (e.g., distressing dreams, flashbacks, or prolonged distress upon exposure), yet still meet criteria for acute stress disorder. The forensic and clinical implication of this change is clear: there will likely be many different presentations of acute stress disorder when using DSM-5 diagnostic criteria.

In contrast, DSM-IV required at least three dissociative symptoms, at least one intrusion symptom, evidence of marked avoidance of stimuli that arouse recollections of the trauma, and marked symptoms of anxiety or increased arousal. DSM-IV was not as precise as DSM-5 in the specific number of symptoms necessary to make the diagnosis; however, DSM-IV required at least some symptom evidence in each category of dissociation, intrusion, avoidance, and anxiety or arousal. Third, the DSM-5 version removes the DSM-IV symptom described as "a subjective sense of numbing, detachment, or absence of emotional response" [5 (p471)], and replaced it with a "negative mood" symptom defined as a "persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings" [4 (p281)]. Finally, under DSM-5, the duration of the symptoms must last at least three days (and no longer than one month) after trauma exposure, whereas DSM-IV only required that the symptoms last for two days (and no longer than one month).

Adjustment disorders

Adjustment disorders are now included in the "Trauma and Stressor-Related Disorders" section, whereas in DSM-IV they had their own chapter. The diagnostic criteria are essentially the same despite the geographic move to another chapter. However, two important changes in the text are noteworthy considerations. First, DSM-5 adds that a "persistent painful illness with increasing disability" can be viewed as an ongoing stressor even if the trigger event (such as an automobile accident) has resolved [4 (p287)]. Second, DSM-5 more clearly states that an adjustment disorder can include

symptoms typically considered associated with PTSD or acute stress disorder. This newly added language reads, "With regard to symptom profiles, an adjustment disorder of either acute stress disorder or PTSD that do not meet or exceed the diagnostic threshold for either disorder" [4 (p288)]. In Mark's case, he would likely meet criteria for an adjustment disorder (with mixed anxiety and depressed mood) in addition to somatic symptom disorder. In particular, he has some PTSD symptoms (i.e., nightmares) but not enough PTSD symptoms to meet the diagnosis. He also has depressive symptoms related to his unresolved pain that he believes is connected to the accident.

Neurocognitive disorders

As with many accidents that involve alleged head trauma, the possibility of a neurocognitive disorder must be carefully considered. DSM-5 lists two types of Neurocognitive Disorders: major neurocognitive disorder and minor neurocognitive disorder. Major neurocognitive disorder is the DSM-IV equivalent of Dementia. In DSM-IV, Dementia specified that the person had to have both memory impairment and at least one of four identified impairments (e.g., aphasia, apraxia, agnosia, or disturbances in executive functioning) to qualify for a diagnosis. In contrast, DSM-5 is less precise in how cognitive impairment is defined. For example, in regard to the diagnosis of major neurocognitive disorder, Criterion A notes that there must be "evidence of significant decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, or social cognition)" [4 (p602)]. According to DSM-5, this cognitive decline must involve concern by the patient, a knowledgeable informant, or the clinician that there has been a significant decline in cognitive function and a substantial impairment in cognitive performance. DSM-5 suggests that this impairment be documented by standard neuropsychological testing or another quantified clinical assessment, but it does not require any specific test. Under the DSM-5 structure, if cognitive deficits are identified, they must interfere with independence in everyday activities to qualify as a major neurocognitive disorder. Mark has not undergone any neuropsychological testing that indicates substantial impairment in cognitive performance, and he has been able to resume work, despite his complaints of pain. He is not likely to meet the criteria for major neurocognitive disorder.

Mark may meet criteria for the new DSM-5 diagnosis of mild neurocognitive disorder. In particular, he complains of memory loss and problems concentrating. In contrast to major neurocognitive disorder, mild neurocognitive disorder requires only a "modest" (as opposed to a substantial) cognitive decline and the cognitive deficits do not interfere with the person's capacity for independence in everyday activities. The evaluator will need to

assess whether Mark's reported symptoms are genuine, result from another DSM5 disorder (such as depression), or are malingered. The evaluation to make this determination will likely involve a combination of neuropsychological testing, instruments designed to assess malingered cognitive impairment, and a structured clinical interview.

Personality change due to another medical condition

The DSM-5 diagnosis of personality change due to a medical condition is virtually identical to the DSM-IV diagnosis called "Personality Change Due to a General Medical Condition," and there are no new forensic implications for this diagnosis. The only minor change noted is the shift of this diagnosis from the DSM-IV section titled "Mental Disorders Due to a General Medical Condition" to the DSM-5 section titled "Personality Disorders."

SUBSTANCE USE DISORDERS AND CIVIL LITIGATION

Important DSM-5 changes related to substance use disorders are highlighted in Chapter 2. To quickly review, DSM-IV established a hierarchical relationship between the diagnosis of Substance Dependence and Substance Abuse, that is, a diagnosis of Substance Dependence excludes the diagnosis of Substance Abuse. It has been pointed out that this hierarchy has resulted in assumptions that Abuse is a milder form of Dependence, that all cases of Dependence also meet criteria for Abuse, and/or that Abuse is the prodrome of Dependence [13].

In DSM-5, the DSM-IV diagnoses of Substance Abuse and Substance Dependence are collapsed into one diagnosis called substance use disorder. DSM-5 codes substance use disorders according to their severity. Severity is based on the number of symptom criteria endorsed with a *mild* substance use disorder suggested by the presence of two to three symptoms, *moderate* by four to five symptoms, and *severe* by six or more symptoms [4 (p484)].

"Addiction," rather than "substance use disorder," is the term commonly used in a variety of medicolegal contexts. In civil litigation, examples include personal injury and wrongful death actions alleging that negligent prescribing practices or use of a manufactured product caused addiction, addiction-related comorbidity and death, accidental overdose, and suicide. Damage assessments in a wrongful death due to any cause may include consideration of the presence of addiction in the deceased and consideration of the person's potential future had the individual not died. Malpractice cases may allege impairment due to the physician's addiction, with resulting negligence causing damages. In addition, Medical Board actions against physicians can

be based upon impairment resulting from addiction. Fraudulent nondisclosure of addiction may be alleged in a life-insurance case involving denial of benefits. Termination of parental rights, child custody, and parental access cases may be influenced by the diagnosis of addiction in a parent. Eligibility to adopt children may be harmed by an addiction diagnosis in a prospective parent. In employment settings, there may be allegations of wrongful termination or failure to accommodate on the basis of an addiction diagnosis, for example, to alcohol. Medical records including a diagnosis of addiction may create problems for job applicants to various governmental agencies and may undermine suitability to obtain security clearance in government or civilian occupations.

With so much attention to addiction in a variety of civil lawsuits, where in DSM-5 is the clinical disorder commonly referred to as "addiction"? The title of the overall section, "Substance-Related and Addictive Disorders," suggests that addiction is a diagnosis therein. For many years, the DSM-IV diagnosis of Substance Dependence has been conceptually and practically used as the equivalent of addiction. There is a long history of the disease or disorder of addiction described as a "dependence syndrome" [14–16]. Collapse of the DSM-IV Abuse and Dependence diagnoses into one diagnosis implies that the resulting DSM-5 Substance Use Disorder diagnosis is not the equivalent of "Substance Dependence" or "addiction." Perhaps to provide conceptual and practical continuity, DSM-5 offers some guidance in its text under the Substance Use Disorders section that reads,

> Note that the word *addiction* is not applied as a diagnostic term in this classification, although it is in common usage in many countries to describe severe problems related to compulsive and habitual use of substances [4 (p485)].

Based upon this text, the DSM-5 diagnosis equivalent to "addiction" would appear to be "severe substance use disorder."

Does a DSM-5 substance use disorder meet the manual's own definition of a distinct "mental disorder?" In its "Use of the Manual" section, DSM-5 states that its disorders "must meet the definition of mental disorder," which is stated to be "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation or behavior" and "are usually associated with significant distress or disability in social, occupational, or other important activities" [4 (p20)]. DSM-5 explains that a "generic diagnostic criterion requiring distress or disability has been used to establish disorder thresholds, usually worded as 'the disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning'" [4 (p21)]. This "generic diagnostic criterion" is included as a requirement for many diagnoses (e.g., major depressive disorder, generalized anxiety disorder, PTSD, etc).

In exploring this issue for a DSM-5 substance use disorder, the descriptive text makes no mention of clinically significant distress or impairment. In the listings of criteria for the substance-specific use disorders, "Criterion A" refers to a "problematic pattern of alcohol use leading to clinically significant impairment or distress, *as manifested by* at least two of the following, occurring within a 12-month period" [4 (p490)] (emphasis added). Does this wording suggest that the presence of at least two of the criteria occurring within a 12-month period is, in and of itself, manifest evidence of clinically significant impairment of distress? This interpretation would seem to elevate the risk of false-positive diagnosis, if the criteria present are simply added up and the total compared with a threshold number. Alternatively, in addition to identifying the presence of the threshold number of criteria, must the diagnostician assess whether the disturbance causes clinically significant impairment or distress? This approach would appear to be in keeping with the DSM requirement that the diagnosis considered also "must meet the definition of a mental disorder." Guidance has been provided in an editorial by one of the Work Group members [17], who writes: "It is important to note that even the mild substance use disorder . . . can only be diagnosed in the context of significant impairment in life functioning or distress to the individual or those around them" [17 (p662)]. Thus, the presence of two or more criteria, assessed to be unaccompanied by clinically significant impairment or distress, would *not* be sufficient to make the diagnosis of a substance use disorder in DSM-5.

In judicial and legislative contexts, the diagnostic and conceptual discontinuity between DSM-IV and DSM-5 approach to substance use disorders may present problems, given that the previous DSM editions, including the DSM-IV, have been cited in court opinions more than 5500 times and in legislation more than 320 times [18]. Unlike the DSM-IV diagnosis of Substance Dependence, which has been more thoroughly researched and has been demonstrated to have excellent reliability and validity, the same is not yet true for the DSM-5 diagnosis of a substance use disorder. It has been noted that the DSM-5 field trials did not compare the DSM-IV and the DSM-5 prevalence rates for the same disorder through head-to-head diagnosis by the same clinician. Instead, the field trials relied primarily on academic medical centers with the most severe cases, rather than typical outpatient settings. Furthermore, there was an extraordinarily high rate of attrition among clinicians approved to participate in the field trials, no tests of predictive validity of the DSM-5 diagnoses were undertaken, planned tests of convergent validity were abandoned, and the threshold requirement for interrater reliability was lowered substantially [19, 20]. It has been predicted [21] that experts adopting the latest edition "will encounter criticisms related to the newness of and inexperience with DSM-5," whereas experts who choose to stick with the DSM-IV "will likely experience aspersions suggesting that their practice

is antiquated and outdated" [21 (p240)]. Therefore, regardless of choice, the forensic expert may need a working knowledge of the issues relevant to DSM-IV and DSM-5, including the changes, rationale, research, criticisms, and the relationship of the new substance use disorder diagnosis to "dependence" and "addiction."

SUMMARY

DSM-5 has reorganized, added, and altered multiple diagnoses in the transition from the DSM-IV. Many of these changes may impact how claims of psychiatric injuries (to include emotional distress) are evaluated in malpractice, personal injury, and "addiction" civil litigation cases. Key summary points for this chapter include the following:

- Medication-induced mental disorders imply causation by virtue of the diagnosis, whereas medication-induced movement disorders may not.
- Somatic symptom disorder is an expansion of previous Somatoform Disorders and does not require the presence or absence of a medical condition to make the diagnosis.
- DSM-5 both expands and restricts different criteria for PTSD, which will likely affect different types of personal injury claims in various ways.
- Revisions to substance use disorders may not easily fit into previous concepts of addictions in the legal system, and the presence of clinically significant impairment is a factor evaluators may need to consider in using these diagnoses.

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